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Health Insurance Association of America

RESEARCH BULLETIN

Monitoring Attitudes of the Public, 1989

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Précis

Most Americans are happy with the health insurance coverage they have and the health care they receive. This conclusion, reflected in HIAA's survey, *Monitoring Attitudes of the Public, 1989* (MAP), closely follows trends observed in past MAP surveys.

But, despite the satisfaction that individual members of the public express about their personal dealings with health insurance and health care, there are indications that, in the mind of the public, all is not well with the U.S. system of providing and paying for health care. As in past years, the dominant public concern is high and rising health-care costs.

Executive Summary

◆ Health Insurance and Health Care

Americans are generally satisfied with most facets of their own health insurance. Among those with insurance protection, 82 percent are pleased with their insurance coverage and the benefits it provides. Seventy-five percent say expressly that they are happy with the specific medical services and treatments covered in their policies, and 72 percent of Americans are satisfied with the proportion of their medical bills covered by health insurance.

People are also fairly happy with claims submission and payment. Eighty-two percent say that filing a claim is "not too" or "not at all" difficult. However, about one-fifth (19 percent) say that they encounter problems when they submit claims. About three out of four people (74 percent) say they are satisfied with how promptly their insurer pays claims.

Satisfaction with health care continues as it has in past years. More than three out of four (79 percent) are happy with the quality of care they receive from hospitals. Similarly, 84 percent like the quality of physician care they receive.

◆ Health Care Costs

In 1988, national health spending reached $539.9 billion, a 10.4 percent increase over 1987. This amounts to about 11.1 percent of the gross national product (GNP) for 1988. The Health Care Financing Administration (HCFA) projects that the nation's health expenditure will reach about $650 billion by the end of 1990.

Given these costs, public concern is not surprising. Only 34 percent of the American people say they are satisfied with the current cost of health care. Seven out of 10 correctly believe that health care costs are rising faster than costs in general. A sizable majority (61 percent) describe their out-of-pocket costs as higher than they would like. Three out of four (75 percent) say that they are concerned about facing health insurance premiums that they cannot afford to pay.

People's confidence in their ability to meet the cost of a major illness in their family has fallen somewhat since the early 1980s, although a majority (61 percent) still feel at least somewhat confident that they could meet the cost. A large majority (71 percent) say that cost seldom or never prevents them from getting the medical care they need.

Americans give mixed reviews to some measures that insurers use to control costs. Most economists believe that increased cost sharing can make people more conscious of their health care spending, and research has documented that it results in lower costs overall. Not surprisingly, this is not a popular approach. A majority (54 percent) of people state that raising deductibles is not a satisfactory measure. Raising copayments is even less popular, with 62 percent saying that it is not acceptable.

This year's MAP attempted to assess public reaction to several cost-containment approaches that have become common in recent years. The questions are hypothetical; many respondents probably have not had direct experience with the cost-containment approaches suggested by the survey. A large majority of the respondents (68 percent) expressed concern about not having control over their own medical treatment. A minority (35 percent) are concerned about a health insurance company reviewing a treatment recommended by their physician. When asked about pre-admission review, about half (51 percent) say it is unacceptable for an insurance company to require approval before admission to the hospital for nonemergency treatment. Forty-one percent say such a program is acceptable.

People who belong to health maintenance organizations (HMOs) express greater satisfaction than do people with other types of coverage. This is true of satisfaction with various components of coverage and cost.

◆ Concerns About Health Insurance Coverage

There are aspects of health insurance coverage that trouble some Americans.

For example, in a series of theoretical questions, peoples' answers reveal uneasiness over the possibility of losing their job-related health insurance. Nearly two-thirds (64 percent) of those with group coverage are concerned about the possibility of losing coverage when they leave a job. A majority (52 percent) expressed concern about being unable to qualify for health insurance when changing jobs because of a health problem, or working part-time and not having insurance.

People are also concerned about hypothetical situations in which insurance payment does not cover the bulk of the bill. Sixty-three percent worry about being denied payment for a claim submitted (though only 17 percent have had such an experience), and 76 percent are concerned about being billed by a physician for more than their insurance will pay.

National Health Insurance

Public opinion polls over the last 20 years show varying amounts of support for national health insurance, depending in large part on how the question is asked. At present, much media attention is focused on the Canadian system and whether or not the United States should adopt such a system.

The 1989 MAP survey posed a question first asked by Louis Harris and Robert Blendon in a cross-national public opinion poll in late 1988 and reported in *Health Management Quarterly*. Harris and Blendon gave a very brief positive description of the Canadian national health insurance system and asked people in three countries, including the United States, which system they preferred. The MAP 1989 survey repeated the Harris/Blendon question and then probed further to find out whether specific elements of the Canadian system really would be popular in this country. Results of the overall preference question show that 45 percent of Americans said they prefer the Canadian system, based on the Harris/Blendon description, and 37 percent prefer the system in the United States.

Those who favor a Canadian approach most desire universal coverage (94 percent) and free choice of providers (94 percent). Eighty-nine percent of those preferring the Canadian approach also endorse having the government set all fees charged by doctors and hospitals and having all health care costs paid for out of taxes. When faced with the idea of "substantially higher" taxes, however, only 57 percent of supporters of the Canadian system still find taxing acceptable. A majority (60 percent) of Canadian system supporters find government control of benefits acceptable.

Private insurance is still highly desired by people who preferred the Canadian system as it was described. Not only do 90 percent want the option of purchasing private insurance for benefits not provided by the government, but many react negatively to prohibitions against private coverage for government-provided benefits (as Canada now imposes). Forty-eight percent feel it is unacceptable to prohibit the option of buying private health insurance to pay for private care if benefits are provided by the government plan. Discontent jumps to 62 percent when it is pointed out that this precludes obtaining private coverage to avoid waiting periods for certain treatments.

By far the most undesirable element in the Canadian system is having to wait for treatment. Eighty-one percent of those who initially prefered the Canadian approach find a waiting period for high-cost treatments unacceptable.

◆ Conclusion

MAP 1989 presents the paradoxical conclusion that Americans are basically happy with their own health care and health insurance coverage but have concerns about the U.S. system of providing and paying for health care. They are dissatisfied with the large number of people who do not have access to health insurance, and they think health care costs are too high. Many are worried that they would lose health insurance coverage if they were to change jobs.

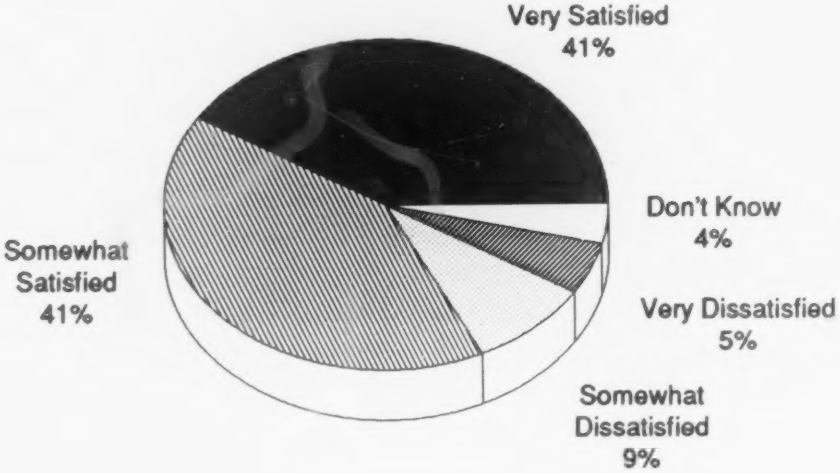
These anxieties may explain in part the apparent abundance of support for "national health insurance" displayed in public opinion polls in the past two years. Rather than actively supporting a government-run program, Americans may be simply expressing their frustration with the gaps in the current system. There is support for this hypothesis in the responses to MAP's series of questions on the Canadian health care system where ambivalence is expressed toward several aspects of government-run health insurance.

The 1989 Survey Findings

◆ Health Insurance Coverage and Services

Americans who have health insurance express a great deal of satisfaction with their coverage and benefits, a large majority (82 percent) are pleased, 41 percent are very satisfied, and 41 percent are somewhat satisfied (see Figure 1). Only 14 percent indicate that they are at least somewhat dissatisfied with their present coverage. People who belong to HMOs are more often very satisfied with coverage (55 percent). This compares favorably to satisfaction levels of those in PPOs (37 percent) and to those holding traditional coverage through commercial health insurance companies (37 percent) or a Blue Cross-Blue Shield plan (35 percent). Satisfaction with coverage increases with age: only 35 percent of people 18 to 24 years old are very satisfied compared to 47 percent of those age

Satisfaction With Present Health Insurance Coverage



Source: 1989 MAP, HIAA

Figure 1

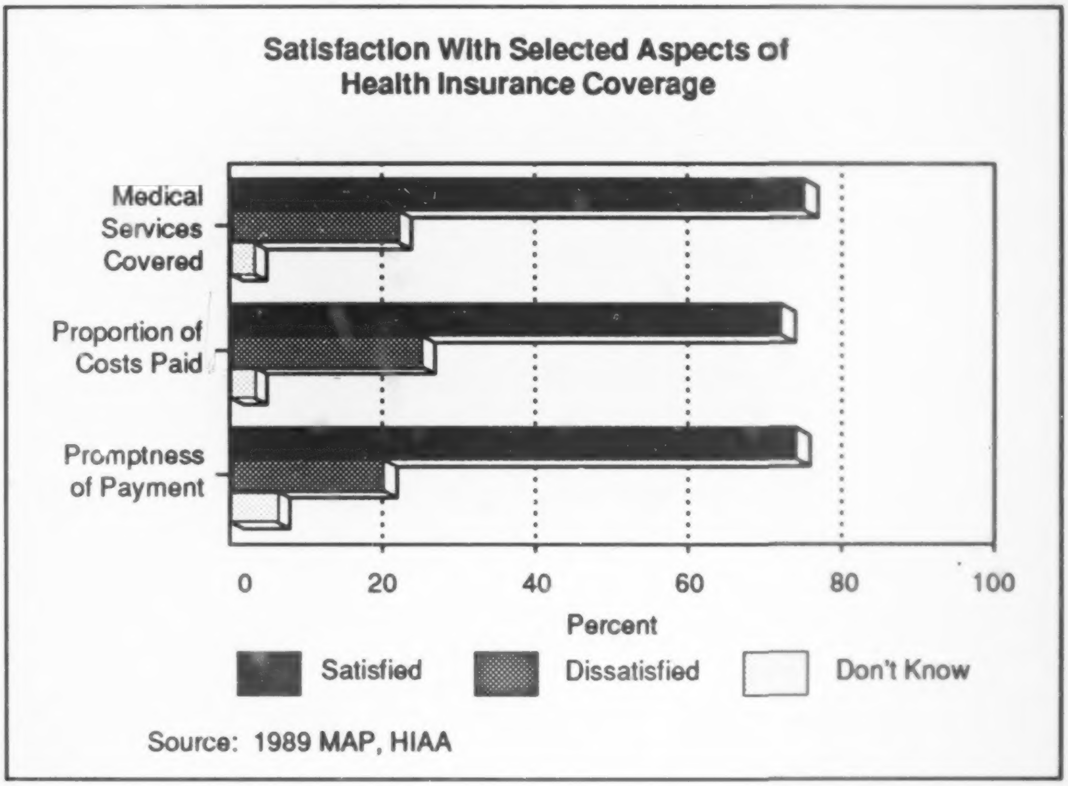


Figure 2

55 to 64 years, and 48 percent age 65 and over. Far fewer of those purchasing individual coverage (30 percent) report being very satisfied compared to those with group coverage through their employer (43 percent).

Americans are generally content with various components of coverage and service provided by insurers. About three-quarters (76 percent) describe themselves as satisfied with the medical services and treatments covered by their health insurance (see Figure 2). Only about one-fifth of the respondents (22 percent) describe any dissatisfaction. People in the Midwest are less satisfied (70 percent) than those in the South or West (79 percent). HMO members are more satisfied (83 percent) than other respondents (74 percent).

Consumers appear pleased with the portion of costs borne by insurers. Seventy-two percent say they are satisfied, and 29 percent are very satisfied (see Figure 2). Again, HMO members

Table 1
Frequency With Which People Made Claims in Previous Year

1989	Percent
Yes, Made Claim	59
No, Did Not Make Claim	40
Don't Know/No Answer	1

express more satisfaction, with 82 percent satisfied about the proportion of costs paid under their plan, compared to 71 percent for people with other types of coverage.

Seventy-four percent of respondents say they are satisfied with how promptly their insurer pays claims (see Figure 2). Twenty percent are not. Responding to a similar question later in the survey, a slightly higher proportion (27 percent) believe that the industry responds slowly to claims. On the issue of promptness of payment, the elderly are more satisfied (81 percent) than are those 18 to 24 years old (63 percent). Eighty percent of those earning less than $20,000 report being satisfied, compared to 71 percent of the more affluent. Fewer urban dwellers (69 percent) are satisfied than are those living in other areas (77 percent).

A majority of respondents with health insurance coverage (59 percent) report having made a claim during the past year (see Table 1). The proportion of those with claims increases with age to the 30 to 34 year old group but, surprisingly, does not continue to rise significantly for groups older than this. More people in the West (67 percent) report making claims than anywhere else. More part-time (71 percent) and unemployed (63 percent) respondents have made a claim than have full-time workers (55 percent). Two-thirds (66 percent) of married people have made claims, whereas only about half (51 percent) of unmarried people have. Far fewer of those with individual insurance (41 percent) made a claim last year.

People also are satisfied with claims submission, though some elements of the process may pose a problem. Fewer than one out of five (17 percent) of those who have filed a claim in the past year have found it difficult (see Table 2). The vast majority (82 percent) say that claim filing is either not too difficult or not at all difficult.

Table 2
Difficulty of Filing Claims

1989	Percent
Very Difficult	4
Somewhat Difficult	13
Not Too Difficult	29
Not At All Difficult	53
Don't Know	1

Nineteen percent feel they encounter problems when they submit claims, whereas 36 percent say such problems are few. A plurality (45 percent) express no strong opinion on the issue.

Consumers appear to have a fairly good understanding of the terms and provisions of their health insurance coverage (see Table 3). Eighty-six percent say that they understand them either very well (35 percent) or fairly well (51 percent). HMO respondents report the greatest understanding of their policies, with 51 percent claiming to understand them very well. By comparison, only 37 percent of those with traditional indemnity coverage through commercial companies and 29 percent of those with traditional Blue Cross-Blue Shield coverage report understanding their coverage very well.

◆ Quality of Health Care

A majority of the public is pleased with the health care they receive. More than three out of four (79 percent) are very or somewhat satisfied with the quality of care provided by hospitals, 84

Table 3
Degree of Understanding Health Insurance Plan Provisions

1989	Percent
Very Well	35
Fairly Well	51
Not Too Well	10
Not At All Well	2
Don't Know	2

Table 4
Degree of Satisfaction with Health Care (in Percent)

	Very or Somewhat Satisfied						
	1978	1980	1982	1984	1986	1988	1989
Quality of Care Recieved from Doctors	84	87	88	88	87	86	84
Quality of Care Received from Hospitals	79	84	82	84	81	78	79
Ability to Obtain Care When Needed	80	81	81	82	82	84	77
	Very or Somewhat Dissatisfied						
	1978	1980	1982	1984	1986	1988	1989
Quality of Care Recieved from Doctors	15	13	12	12	12	11	13
Quality of Care Received from Hospitals	20	15	18	16	14	13	16
Ability to Obtain Care When Needed	20	18	18	18	16	12	20

Numbers do not total 100% due to "do not know" answers or non-responses.

percent report being very or somewhat satisfied with the quality of care they receive from doctors (see Table 4). Satisfaction with the ability to obtain health care when needed reached a high point in 1988, although levels have not fluctuated much through the ten-year period that this item has been measured. In 1988, 84 percent reported being very or somewhat satisfied and only 12 percent reported being very or somewhat dissatisfied. In the 1989 survey, there is a shift back to slightly lower levels, with only 77 percent reporting being very or somewhat satisfied and 20 percent being

Table 5
Degree of Concern About Having Unnecessary Surgery

1989	Percent
Very Concerned	42
Somewhat Concerned	22
Not Too Concerned	23
Not At All Concerned	13

very or somewhat dissatisfied. Though not strikingly different from other years, 1989 shows the lowest satisfaction levels of any year that this question was asked.

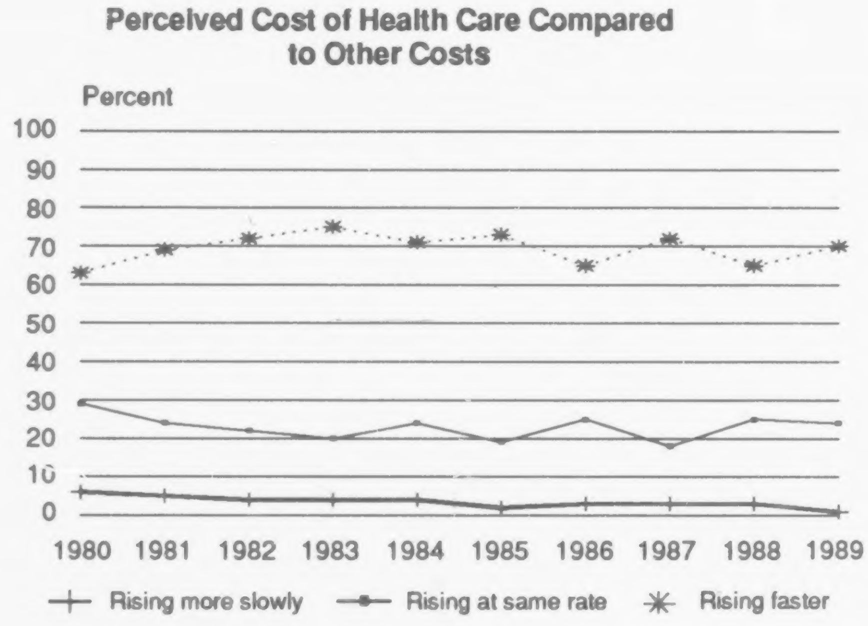
Satisfaction with these components of health care is relatively similar among all demographic groups, except that the more affluent are more satisfied with both the quality of care they receive and their ability to obtain it.

A large majority (64 percent) of people say they are concerned about the possibility of having surgery performed when it is unnecessary (see Table 5).

◆ Health Care Costs

As in past years, the high and rising cost of health care is a dominant concern. A majority of Americans (70 percent) correctly believe that health care costs are rising faster than costs in general (see Figure 3). This proportion is up from 65 percent in 1988, although the percentage has fluctuated with little consistent pattern since 1980. During this decade, roughly two-thirds to three-quarters of the public think health care cost inflation outstrips inflation in general. Only in 1980 were they wrong.

Only 34 percent of the public are satisfied with the costs of medical care (see Figure 4). This pattern has changed little from 1988; however, both 1988 and 1989 percentages are slightly higher than those of previous years. The proportions of those satisfied are particularly low in the Midwest (27 percent) and high among those age 65 and older and blacks (42 percent each). A majority of HMO members are satisfied with costs (54 percent), whereas only 30



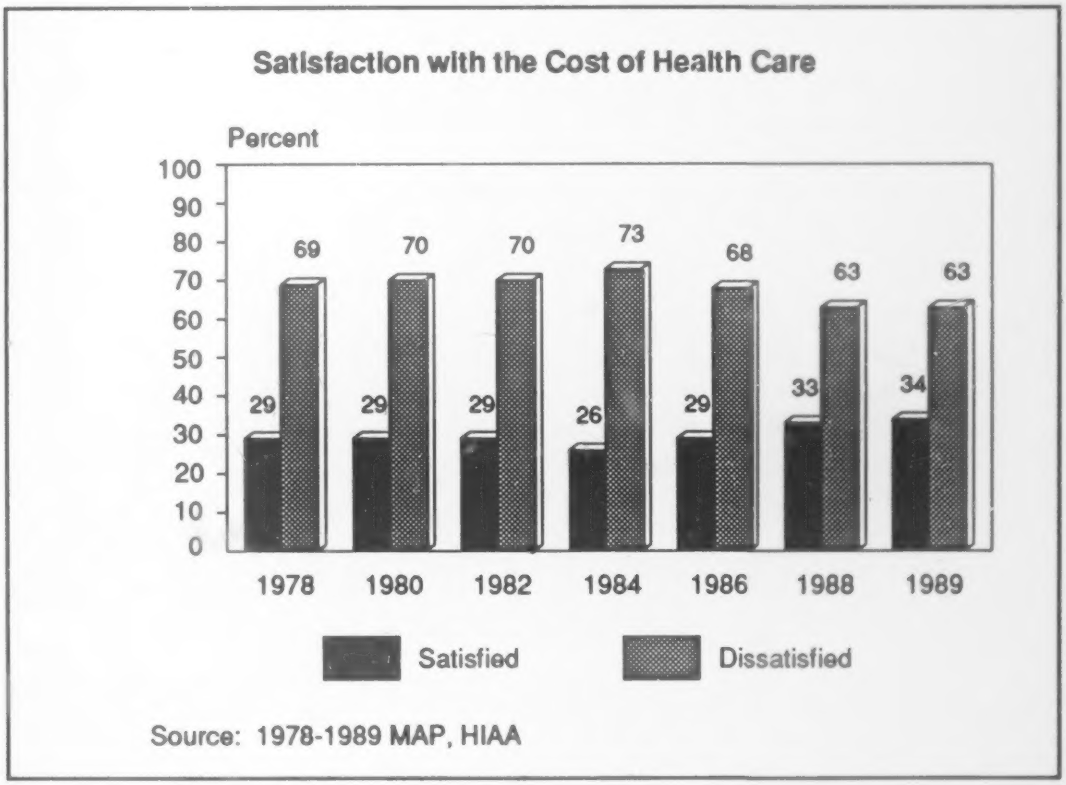
Source: 1980-1989 MAP, HIAA

Figure 3

percent of those who have traditional insurance through a commercial company express satisfaction. Thirty-two percent of PPO eligibles and 38 percent of Blue Cross-Blue Shield plan members are satisfied with costs. As might be expected, only 14 percent of those without health insurance coverage are satisfied with health care costs.

As in past MAP surveys, the public was questioned about what they think causes health costs to rise (see Figure 5). A great deal of responsibility was placed on hospitals (61 percent) and doctors (59 percent). While the proportion of people who blame hospitals for rising health care costs declined steadily from 1983 (79 percent) to 1988 (57 percent), it rose significantly in 1989 (61 percent). The proportion of the public placing blame on doctors continues its downward trend of the past five years.

Only 41 percent of the public think that health insurance companies have a great deal of responsibility for rising costs. This is a



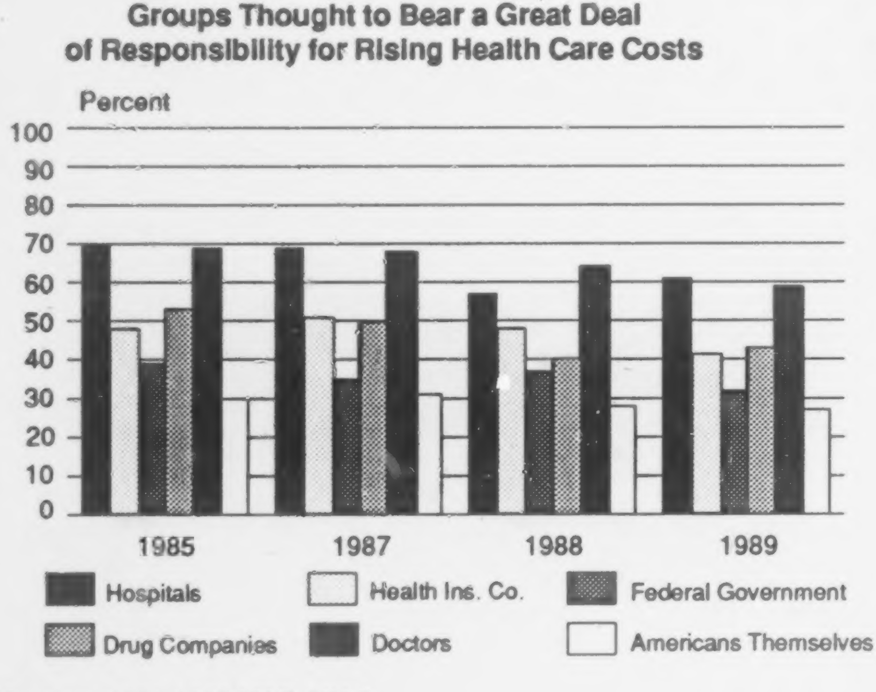
Source: 1978-1989 MAP, HIAA

Figure 4

significant drop from the 48 percent who held that opinion in 1988 and is the lowest percentage in the past five years. The public also assigns less blame to the federal government (32 percent) and the American people themselves (27 percent). The percentage blaming the federal government a great deal (32 percent) has dropped from 37 percent in 1988.

People who assign responsibility for rising costs to health insurance companies were asked why they feel this way. The most frequent answer was the profits earned by companies (35 percent), followed closely by the industry's lack of success in controlling the costs of doctors and hospitals (31 percent). (See Table 6.) Eleven percent blame insurers' administrative expenses and 14 percent cite other factors.

When asked about other factors contributing to rising health care costs, 65 percent place a great deal of responsibility on malpractice suits, and 48 percent say that fraudulent claims are also to



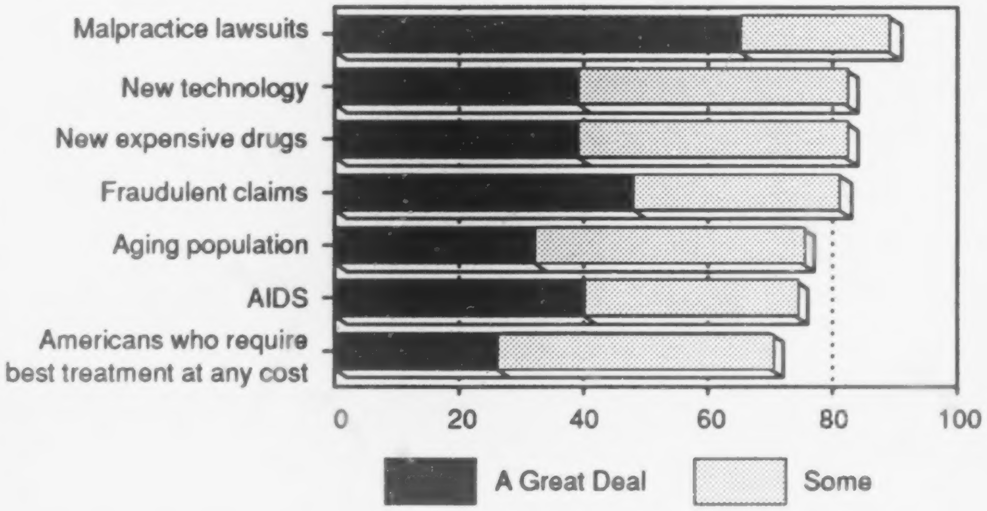
Source: 1985-1989 MAP, HIAA

Figure 5

blame (see Figure 6). The next most reported items were the increasing prevalence of AIDS (40 percent) and new technology (39 percent). Thirty-two percent think an aging population has much to do with rising costs, and only about one-quarter (26 percent) believe that the American public's desire for the best treatment at any expense contributes to high health care costs.

Table 6
Responsibility for Rising Health Care

1989	Percent
Profits Earned by Health Companies	35
Health Insurance Companies That Do Not Control Doctors and Hospitals	31
Administrative/Paperwork Expenses	11
Other	13
Don't Know/No Answer	10



Amount of Responsibility for Rising Health Care Costs

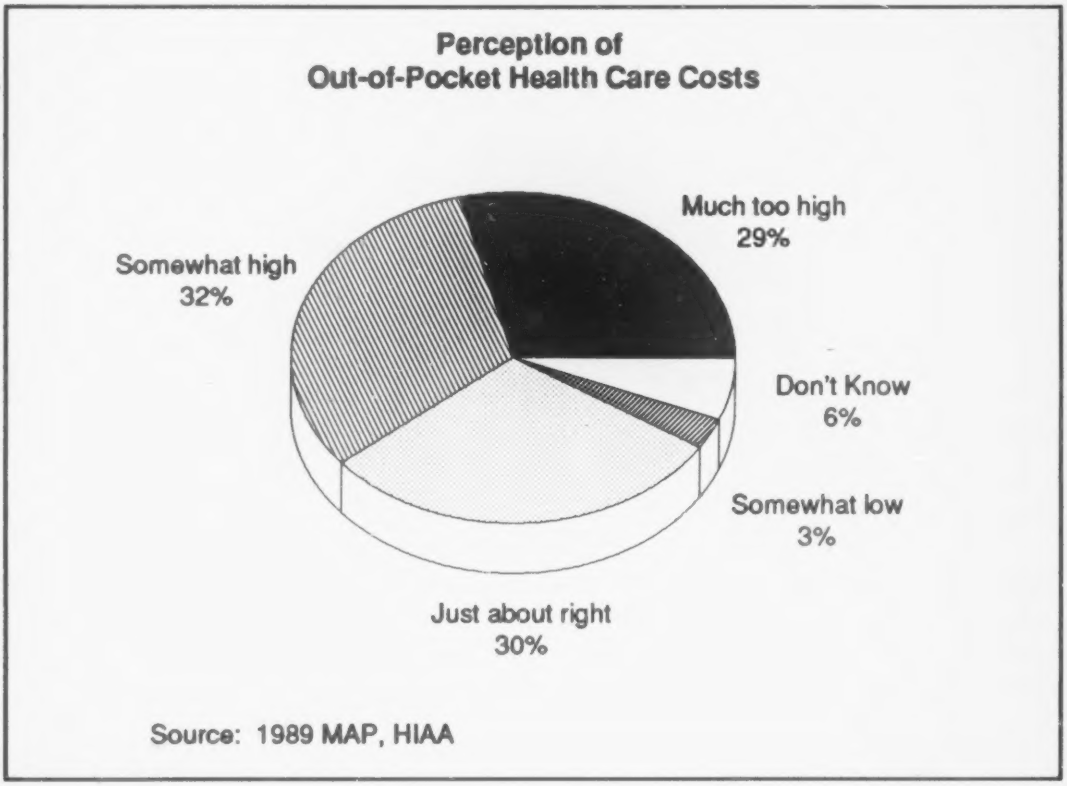
Source: 1989 MAP, HIAA

Figure 6

◆ Personal Health Care Costs

The survey asked people about their own and their family's personnel costs. When asked how satisfied they are with their out-of-pocket costs, a majority (61 percent) of Americans describe them as somewhat or much too high (see Figure 7). Slightly less than one-third (30 percent) feel that their out-of-pocket costs are just about right.

Females (64 percent) more frequently tend to view their out-of-pocket costs as too high than do males (58 percent). Regional differences are apparent, too, with 68 percent of Southerners reporting out-of-pocket costs to be too high, compared to 61 percent of Westerners, 60 percent of Midwesterners and only 53 percent of those from the Northeast. Education seems to be a factor, with 64 percent of respondents with less than a college education finding out-of-pocket costs too high compared to only 51 percent of college graduates. Predictably, people with lower incomes have

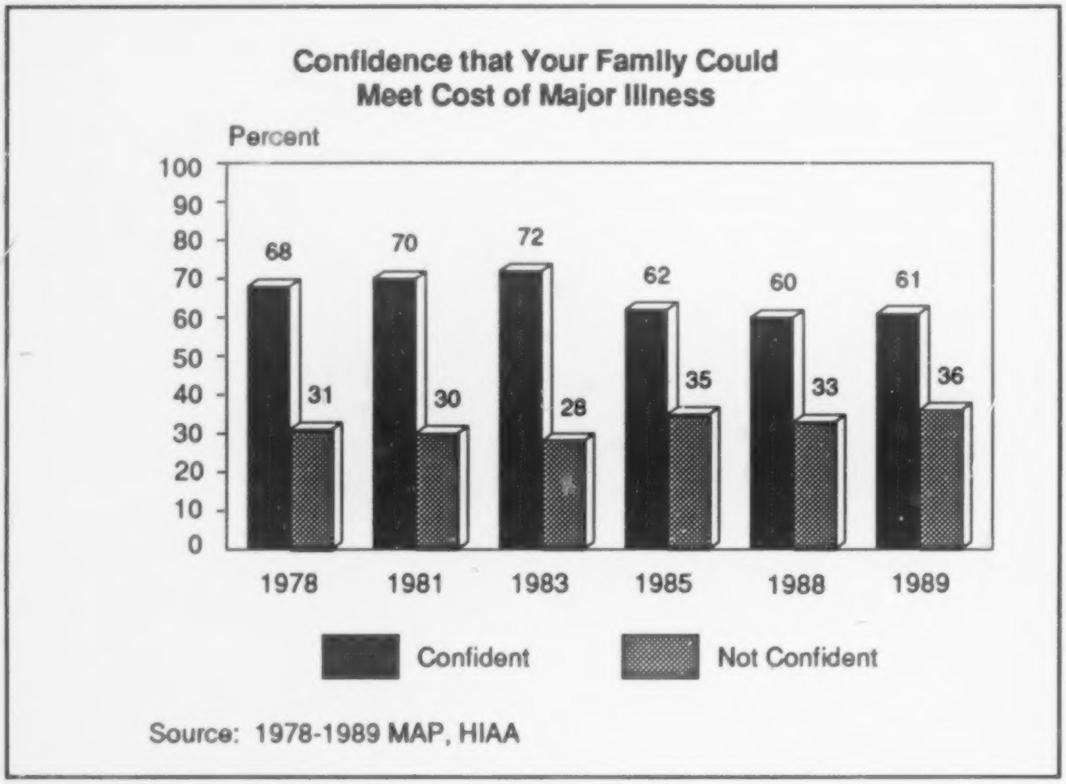


Source: 1989 MAP, HIAA

Figure 7

more trouble paying out-of-pocket costs. Seventy percent of those earning less than $20,000, 59 percent of those making $20,000 to $40,000, and only 55 percent of those earning $40,000 or more say that costs are too high. Fewer HMO members (44 percent) find their out-of-pocket costs too high than do those with traditional coverage through a commercial insurer (67 percent), those having Blue Cross-Blue Shield (60 percent), or those in a PPO (63 percent).

When asked to estimate confidence in their ability to meet the costs of a major illness in the family, a majority (61 percent) of Americans feel very or somewhat confident (see Figure 8). This proportion is almost identical to the comparable figures for 1985 (62 percent) and 1988 (60 percent) but is significantly less than the percentage of respondents who said they were confident in the period from 1978 to 1983. People's confidence in their ability to pay for catastrophic medical care has declined since 1985.



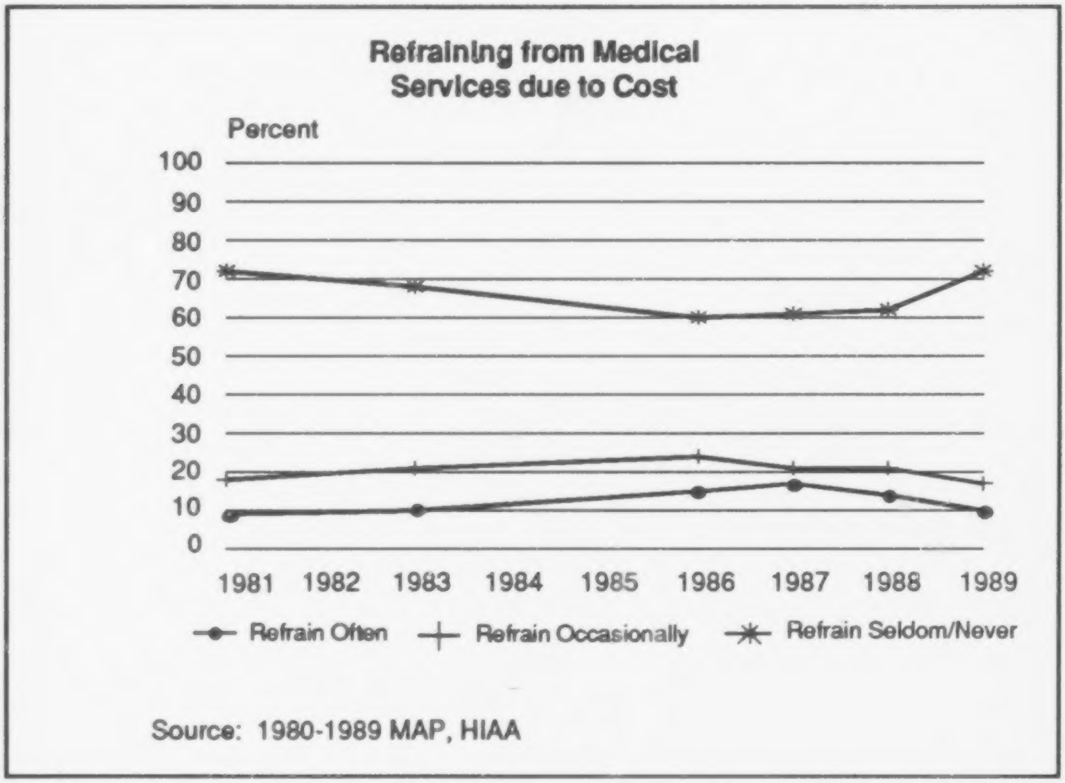
Confidence that Your Family Could Meet Cost of Major Illness

Source: 1978-1989 MAP, HIAA

Figure 8

This confidence is greater in older Americans, with 65 percent of persons age 55 to 64 and 72 percent of 65-year-olds expressing confidence in their ability to meet the costs of a major illness. It is unclear whether eligibility for Medicare (among the 65 plus group) or an effect related to accumulated assets (beginning in the 55 to 64-year-old group and increasing with age), accounts for the greater confidence. Among those younger than 55, only between 53 percent and 61 percent express confidence. There is also a steady increase by income in the proportion of those feeling confident, from 42 percent among those earning under $7,500 to 73 percent among those earning over $50,000. The insured status of the individual has by far the largest effect on confidence in meeting costs. Only about one quarter of the uninsured (24 percent) are confident, compared to 67 percent of the insured.

Those interviewed were asked how often the costs of obtaining medical care keeps them from going to the doctor or buying


Refraining from Medical Services due to Cost

Source: 1980-1989 MAP, HIAA

Figure 9

medicine (see Figure 9). A majority (71 percent) of respondents say that cost seldom or never prevents them from obtaining care. About one out of four respondents (27 percent) say they often or occasionally cannot go to the doctor or buy medicine because of costs. Between 1981 and 1986, the proportion of respondents declaring that they forego medical treatment at least occasionally because of high costs grew from 27 percent to 39 percent. This year, that proportion has fallen back to the 1981 level.

Women are more likely (31 percent) than men (22 percent) to refrain from medical care because of cost, and those over age 65 are far less likely (15 percent) to do so. As might be expected, there is a steady decline in the proportion of people who avoid treatment because of cost as earnings rise (from 39 percent of those earning under $20,000 a year to only 18 percent among those making more than $40,000 a year). More than half (59 percent) of the uninsured often or occasionally refrain from seeking medical care because of cost.

Table 7
Concern About Affordability of Health Insurance

1989	Percent
Very Concerned	42
Somewhat Concerned	33
Not Too Concerned	17
Not At All Concerned	7
Don't Know	1

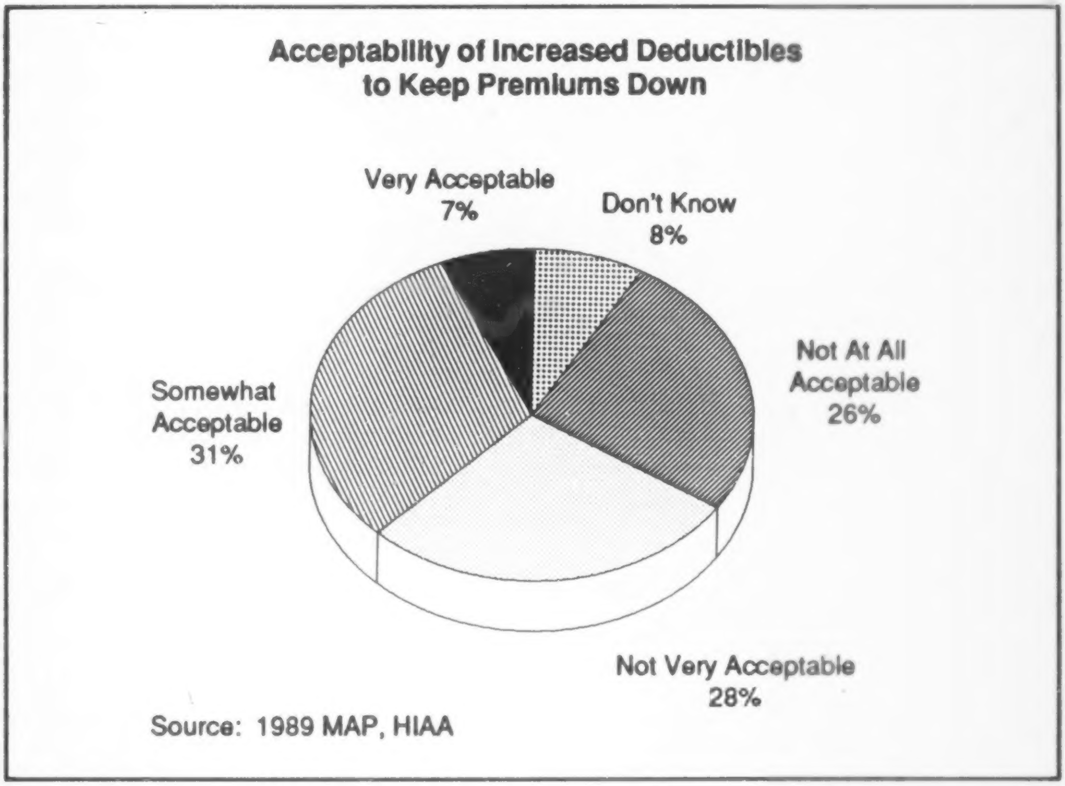
Finally, 75 percent say they are concerned about facing health insurance premiums that they cannot afford (see Table 7).

◆ Cost Containment Initiatives

Given the importance of the health care cost issue, 1989 MAP included questions about the acceptability of some of the means used to control costs. First, respondents were asked how acceptable they would find two possible ways to keep premiums down in the long run — increased deductibles and increased copayments.

Increased cost sharing is not a popular approach. When asked to rate the acceptability of increased deductibles, a majority (54 percent) of people with some type of health coverage indicate that this proposal is either not very acceptable — 28 percent — or not at all acceptable — 26 percent. (See Figure 10.) On the other hand, more than one-third of the respondents (38 percent) stated that increasing deductibles would be acceptable in the interest of keeping premiums down. Presumably because they pay premiums directly, people with individually purchased insurance are more likely to find increased deductibles acceptable (47 percent) than are those with group coverage (37 percent), if lower premiums would result.

Reaction to increased copayments is even more negative. More than six in 10 express disapproval, with 32 percent saying that it is not very acceptable and 30 percent saying that it is not at all acceptable (see Table 8). Only 28 percent indicate that they would



Source: 1989 MAP, HIAA

Figure 10

find increased copayments an acceptable approach. Disapproval is highest among those age 35 to 44 years (73 percent) and is lowest among ages 18 to 24 (46 percent). More people from the West disapprove (69 percent) than do those from other regions (average: 60 percent).

The 1989 MAP survey attempted to assess public reaction to several cost-containment approaches that have become common

Table 8
Acceptability of Increasing Copayments

1989	Percent
Very Acceptable	4
Somewhat Acceptable	24
Not Very Acceptable	32
Not At All Acceptable	30
Don't Know/No Answer	10

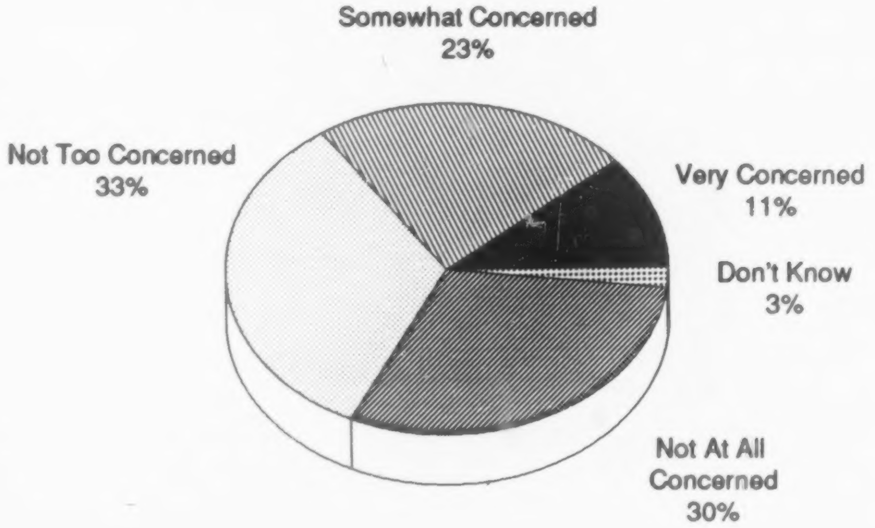
Table 9
Acceptability of Increasing Copayments

1989	Percent
Very Concerned	41
Somewhat Concerned	27
Not Very Concerned	21
Not At All Concerned	10
Don't Know/No Answer	1

in recent years. The results are difficult to interpret because, for many respondents, the questions are hypothetical. Accordingly, a large majority (68 percent) of people expressed concern about not having control over their own medical treatment (see Table 9). This loss of control is more of an issue to Baby Boomers (73 percent) than to others (66 percent). People from the Midwest (73 percent) and West (74 percent) express more concern about control than do residents of the Northeast and South (64 percent each). Three out of four (74 percent) respondents with children living at home are sensitive to this issue, compared to 65 percent of those without children at home. The uninsured (to whom not having control might mean not having access to treatment) express considerable concern, with 81 percent saying they are concerned about not having control over their own medical treatment, compared to 68 percent of those who have group coverage and 62 percent who have individually purchased coverage.

When respondents were asked to gauge their level of concern about health insurance company review of the treatment recommended by their physician, only 34 percent of those with coverage reported being at least somewhat concerned, while 63 percent were not concerned (see Figure 11). Fewer of those with less than a high school education (27 percent) are concerned, compared to the proportion found among the more educated (36 percent).

A slight majority (51 percent) of the public thinks that it is unacceptable to have to obtain approval from an insurance company before hospital admission for nonemergency treatment (see Table 10). Forty-two percent find pre-admission review acceptable. The



Concern Over Health Insurers Reviewing Treatment Recommendations of Physicians

Source: 1989 MAP, HIAA

Figure 11

more affluent are more accepting of pre-admission review than others (47 percent of those earning $40,000 or more find it acceptable compared to 39 percent of those with lower incomes). Forty-four percent with employer-provided or government-provided health insurance find it acceptable, versus 35 percent of those purchasing their own insurance.

It is difficult to explain why people with group coverage (compared to individual coverage) are more concerned with not having control over their own treatment, while they show less concern about pre-admission review. Preadmission review programs are more prevalent and well established in group business, and perhaps direct experience with them makes people with group coverage realize they are not difficult to live with.

Table 10
Acceptability of Obtaining Prior Approval for Nonemergency Hospitalization

1989	Percent
Very Acceptable	10
Somewhat Acceptable	32
Not Too Acceptable	26
Not At All Acceptable	25
Don't Know/No Answer	7

◆ Concerns About Health Insurance Coverage

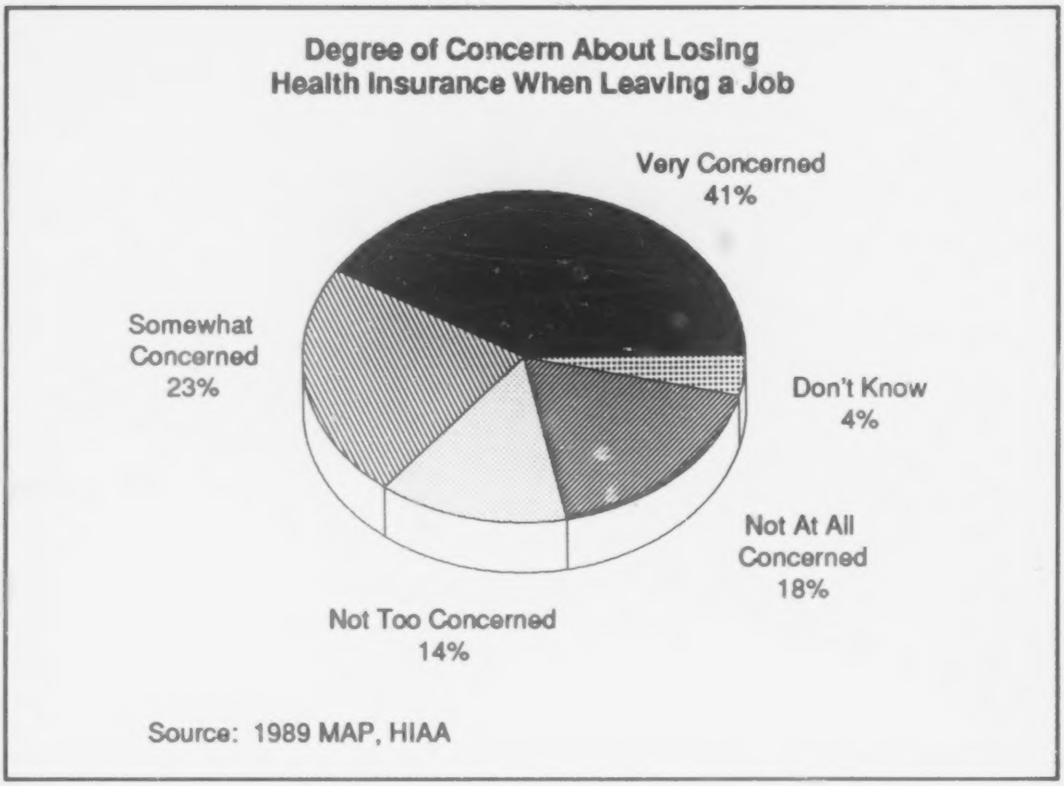
People who have group health insurance coverage were asked hypothetical questions about their level of concern about situations in which they or their family members could lose health insurance for job-related reasons. Again, given the theoretical nature of the questions, it is difficult to interpret the answers, although it appears that there is concern about loss or denial of health insurance.

People express the most concern about the possibility of losing health insurance when leaving a job, with 64 percent saying they are either very or somewhat concerned about facing this situation (see Figure 12). Concern is highest among Baby Boomers (72 percent), those with children at home (70 percent), and those making more than $40,000 per year (68 percent).

Fewer, but still a majority (52 percent), say they are concerned about the prospects of being unable to qualify for health insurance when changing jobs because of a health problem, or working part-time and not having health insurance (see Table 11).

All MAP respondents were asked further hypothetical questions about some other health- and health insurance-related questions.

- About two-thirds (65 percent) said they are concerned about being denied insurance because they have a health problem (see Table 12). The uninsured (76 percent) are particularly sensitive about this prospect.



Source: 1989 MAP, HIAA

Figure 12

- People state concern about circumstances in which insurance payment covers only a small portion of the bill or is denied altogether. Seventy-six percent of Americans say they are concerned about being billed by a physician for much more than their insurance will pay.
- Sixty-three percent are concerned about being denied payment for a claim they have submitted. People with children under 18 are more concerned (67 percent) about this than are those without young children (61 percent). HMO members are less concerned (57 percent) than people with coverage through a commercial health insurance company (64 percent) or those with Blue Cross (67 percent).

Though much concern is expressed about the possibility of being denied payment, very few people have had the experience. When asked whether people have had an actual experience where they felt they had a valid claim that their insurer would not pay, 17 per-

Table 11
Concern about Possibility of Losing Health Insurance Coverage,
(In Percent)

	Very Concerned	Somewhat Concerned	Not Too Concerned	Not At All Concerned
Unable to Qualify for Insurance When You Change Jobs	33	19	19	25
Working Part-time and Not Having Health Insurance	32	20	18	25

Numbers do not total 100% due to "do not know" answers or non-responses.

Table 12
Degree of Concern Over:
(In Percent)

	Very Concerned	Somewhat Concerned	Not Too Concerned	Not At All Concerned
Being Denied Insurance Because of a Health Problem	40	25	21	13
Being Billed for More Than Insurance Will Pay	46	30	16	8
Being Denied Payment of Claim	38	25	23	13

Numbers do not total 100% due to "do not know" answers or non-responses.

cent said they have while 82 percent have not. Those in major metropolitan areas have had this problem less frequently (13 percent) than others.

◆ National Health Insurance

Over the years, questions about national health insurance have been part of MAP. The 1989 MAP posed a question first asked by Louis Harris and Robert Blendon in a cross-national public opinion

Table 13
Preference for Canadian System Description Versus U.S. System

1989	Percent
Prefer Canadian System	45
Prefer Own System	37
Don't Know/No Answer	18

poll in late 1988 and reported in *Health Management Quarterly*. Harris and Blendon gave a very brief positive description of the Canadian national health insurance system and asked people what system they prefered. The 1989 MAP repeated the question but then probed further to find out the popularity of various elements of the Canadian national health insurance system. The original question reads:

> "In the Canadian system of national health insurance, the government pays most of the cost of health care for everyone out of taxes, and the government sets all fees charged by doctors and hospitals. Under the Canadian system people can choose their own doctors and hospitals. On balance, would you prefer the Canadian system or the system we have here?"

Based on this description, 45 percent of MAP respondents preferred the Canadian system, whereas 61 percent of Blendon's respondents preferred it (see Table 13). In both surveys, 37 percent of the respondents said they prefer the system in the United States. Eighteen percent of MAP respondents said they do not know or cannot make a decision based on the information given, while only 2 percent of Blendon's respondents were uncertain.

Both figures (45 percent and 61 percent who prefer the Canadian system) are plausible when compared to data from historical public opinion polls asking about national health insurance. Over the past 20 years, from one-third to two-thirds of the public say they favor some form of national health insurance, depending on how the question is asked and how the survey is performed.

Preference for the Canadian system varies by age. Fifty-four percent of "Baby Boomers" prefer the Canadian system as described by Blendon, compared to only 40 percent of all others. Respondents age 55 and over tend to select the U.S. system with greater frequency than younger ones. More of those with children at home (53 percent) show a preference for the Canadian system than do those who do not have children at home (40 percent). The uninsured are more likely to prefer the Canadian system (53 percent) as are those in PPOs (57 percent) and HMOs (49 percent).

Those who expressed a preference for the Canadian system were asked what components they found acceptable. While a plurality of Americans said they prefer the Canadian system based on the general description they were given, support for various components was mixed. Some elements of the Canadian system were viewed positively but other components had very low support. The subgroup that preferred the Canadian system found two especially attractive elements to be allowing people to choose their own physician or hospital, and universal coverage (94 percent of the subgroup reacted positively to both of these elements). (See Table 14.) Eighty-two percent of the subgroup said that continuing to have a choice of providers is very acceptable.

About nine out of 10 (88 percent) of those who preferred the Canadian system thought fee control for doctors and hospitals was an attractive element. Equally popular (90 percent) was the idea that health care costs be paid out of taxes.

Tax funding of the system became much less popular to the subgroup, however, when the respondents became aware that taxes would increase as a result. When faced with the idea of "substantially higher" taxes to fund the system, only 57 percent still found taxing acceptable.

A majority (60 percent) of Canadian system supporters found government control of benefits to be an acceptable measure, but, significantly, 91 percent wanted to retain the ability to insure privately benefits not provided by the government.

Clearly, private insurance is still desired even by the people who say they prefer the positively described Canadian system. Not only did 91 percent want the option of purchasing private insurance for benefits not provided by the government, but many reacted

Table 14
How Acceptable Would You Find the Canadian System If Each Listed Aspect Were Included in the System?
(Limited to Respondents Preferring Canadian System)

	Very Acceptable	Somewhat Acceptable	Not Very Acceptable	Not At All Acceptable
People Can Choose Own Doctor and Hospital	82	12	2	1
Insurance Covers Everyone	74	20	2	2
Option to Buy Benefits	58	33	4	1
Government Sets Fees for Doctor/Hospital	56	32	6	2
Government Pays Cost out of Taxes	53	37	4	3
Government Controls Benefits	23	37	25	11
No Option of Buying Insurance for Private Health Care for Benefits Covered by Government	18	28	32	16
System Requires Higher Taxes	14	43	27	12
No Option of Buying Insurance to Avoid Waiting for Treatment That System Covers	10	20	37	25
Patients Wait Months for Treatment	6	9	40	41

Numbers do not total 100% due to "do not know" answers or non-responses.

negatively to prohibitions against private coverage for government-provided benefits (such as exist in Canada). Forty-eight percent felt it was unacceptable to prohibit the option of buying private health insurance to pay for private care even if benefits are provided by the government. This discontent jumped to 62 per-

Table 15
How Insurance Is Obtained

1989	Percent
Through Own or Spouse's Employer	54
Through Government (Medicaid/Medicare, VA, CHAMPUS)	18
Buy Own Health Insurance	11
No Health Insurance	14
Other	3

cent when it was pointed out that this prohibition also precludes private coverage which could be used to avoid waiting periods for certain treatments.

Rationing is by far the most undesirable element in the Canadian system. Eighty-one percent of those preferring the Canadian system found waiting periods of many months for high cost treatments, such as cataract or heart by-pass surgery, unacceptable.

◆ Source of Health Insurance Coverage

Fifty-four percent of the public obtains primary health insurance through an employer or a spouse's employer (see Table 15). Eleven percent buy it individually. Eighteen percent obtain coverage through government programs. Fourteen percent do not have health plan coverage.

In the United States, access to insurance is tied to socioeconomic status. For example, far more of those earning more than $20,000 a year (74 percent) get their insurance through work than those earning less than $20,000 (30 percent). Considerably higher proportions of married people (70 percent) and homeowners (64 percent) get their health insurance through work.

Fourteen percent of respondents report not having any health insurance. This compares to 13 percent of the population reported as uninsured during the last quarter of 1988 in the Survey of Income and Program Participation conducted by the U.S. Bureau of the Census. MAP shows that people who have lower incomes

Table 16
Type of Insurance

1989	Percent
Commercial Insurance	25
Blue Cross/ Blue Shield	19
Medicare	11
HMO	11
PPO	7
Other Government Programs (VA, CHAMPUS)	5
Medicaid	3
Other	3
Uninsured	14
Don't Know/No Answer	2

(23 percent of those earning less than $20,000 a year) and those with less than a high-school education (26 percent) are more likely to lack health insurance. Age has a tremendous effect on the tendency not to have health insurance. Twenty-seven percent of those age 18 to 24 years, and 17 percent of those 25 to 29 years say they are uninsured, compared to 12 percent of the 30 to 64-year olds. A far higher proportion of people in the South (18 percent) and West (17 percent) are without health insurance than in the Northeast (9 percent) and Midwest (9 percent).

One out of four respondents reports having a traditional indemnity health insurance plan through a commercial health insurance company (see Table 16). Two out of 10 (19 percent) report being covered by a Blue Cross-Blue Shield plan; 11 percent belong to an HMO plan; 7 percent belong to a PPO plan; 11 percent are covered by Medicare; 3 percent say they are covered by Medicaid; and 5 percent are covered by another government program.

These coverage figures correspond well to data from other sources, except that the PPO figure is roughly half what it should be and the HMO statistic is a few percentage points too low.

Coverage by commercial health insurance companies tends to be higher outside major metropolitan areas (28 percent) and in the

Table 17
Self-Assessment of Health,
(In Percent)

	1989	1988
Excellent	34	40
Good	46	44
Fair	16	13
Poor	4	3

Midwest (28 percent) and South (30 percent). Blue Cross-Blue Shield coverage is highest in major metropolitan areas (23 percent) and twice as high in the Northeast (35 percent) as anywhere else. HMO membership is highest in more populated areas (14 percent) and in the West (16 percent) and Midwest (16 percent). The proportion of those belonging to a PPO is highest in the West (13 percent).

◆ Personal Health

As in the 1988 MAP, the public was asked to describe their health. A majority (80 percent) say that their health is either excellent or good (see Table 17). The proportion saying their health is excellent is significantly lower than the percentage of respondents who described their health that way in 1988. Twenty percent report having fair or poor health.

Education and income influence health descriptions. College graduates (91 percent) are more likely to claim good health than those without college degrees (78 percent). Respondents earning $40,000 or more a year (91 percent) report better health than those earning $20,000 or less (64 percent).

Methods

A nationwide cross section of 1,484 men and women, 18 years of age and over, was interviewed for the 1989 MAP survey in face-to-face interviews in respondents' homes. The fieldwork and tabulation of the 1989 MAP survey was conducted by the Roper Organization, Inc.

◆ Sampling Method

The persons interviewed in this study comprise a representative sample of the population of the continental United States, age 18 and up—exclusive of segments of the population institutionalized in military bases, nursing homes, prisons, etc.

A multi-stage stratified probability sample of interviewing locations is employed in this research. The probabilities of selection at each stage are based on the latest U.S. Bureau of the Census population data, and detailed Census maps are used to identify and locate the selected areas.

At the first stage, counties in the 48 contiguous states and the District of Columbia are ordered by population size within 18 strata. (The strata are constructed by classifying counties as metropolitan and non-metropolitan within each of the 9 Census Geographic Divisions.) One hundred counties are then selected with probabilities proportionate to population.

At the second stage, within each primary sampling unit, two Census block groups—or Census Enumeration Districts, when Census block statistics data are unavailable—are selected with probabilities proportionate to a population from a computer listing in which the block groups (EDs) are stratified by size of place in which located.

At the third stage, within each sample block group (ED), two sample locations (blocks or rural equivalents of blocks) are selected. Where Census block data are available, the sample blocks are selected with probability proportionate to size (population) from a cumulative computer listing. When no such block data are available, sample Enumeration Districts are broken into identifiable segments (small areas defined by roads, streams, railroad tracks, or other unambiguous boundaries), and the sample segments are selected with equal probability.

At the block (segment) level, the interviewer is assigned a starting point and a path to proceed around the sample area. Quotas for men and women over and under age 45 are imposed, as are quotas for employed people. In addition it is required that interviewing on half the assigned blocks (segments) be conducted after 5 PM on weekdays or on Saturday or Sunday, to facilitate fulfilling the employment quota. While the assigned quotas produce the proper number of men and women over and under 45. Small age-related imbalances show up when the sample is examined in finer age groups. There are too few 18-29 year olds and too many 30-44 year olds. Accordingly, the sample is weighted to achieve the correct proportions of men and women age 18-29, 30-44, 45-64, and 65 and over.

A validation is made by telephone of all interviewers' work from the Roper centralized telephone facility.

◆ Interviewing Dates

Interviewing for this study began as soon as the interviewers received their materials on May 20, 1989 and was completed June 10, 1989.

◆ Statistical Reliability

The sampling procedure used in MAP is designed to produce a sample that approximates the adult population 18 years and older, living in private households. The survey results can be applied to this population for purposes of projecting percentages into numbers of people as well as in terms of numbers of households.

All survey findings are subject to sampling error. Sampling error is the extent to which the results may differ from those that would be obtained if the whole population surveyed had been interviewed. The following table gives the expected tolerances for various reported proportion at the .05 level of confidence (95 percent).

Percentage Reported:	Completed Interviews: 1,500
50	+/-3
40 or 60	+/-3
30 or 70	+/-3
20 or 80	+/-2
10 or 90	+/-2
5 or 95	+/-1

The following table below gives the expected tolerance for various reported proportions at the .05 level of confidence (95 percent) when comparing two samples of 1,500 each. When comparing trend data from year to year, the following tolerances should be used.

Percentage Reported:	**Comparing Two Samples of 1,500 Respondents in Each Sample**
50	+/-4
40 or 60	+/-4
30 or 70	+/-4
20 or 80	+/-3
10 or 90	+/-3

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RESEARCH BULLETIN

Long-Term Care Insurance: A Market Update

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The Health Insurance Association of America

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Preface

Long-Term Care Insurance: A Market Update continues to chronicle the changing long-term care insurance market; in addition, it contains limited information on market and claims experience of HIAA member companies. All information is based on data gathered and analyzed by HIAA staff, who used several data sources. The status of the overall marketplace is based on two telephone surveys of all companies known to sell long-term care insurance; the surveys were conducted in December 1989 and June 1990. The analysis of leading sellers of long-term care insurance is based on telephone interviews, policy forms and marketing materials that reflect each company's most recently issued policy as of early 1990. The analysis of company experience in the long-term care market is based on a mail questionnaire with telephone follow-up and was completed by HIAA member companies selling long-term care insurance as of late 1989. (Experience through June 1989 was reported.) Information presented herein reflects these differing time frames and is so noted in the text.

For assistance in gathering and analyzing the data contained in this report, we would like to thank Seth Freedman, a colleague in HIAA's policy development and research department. We also would like to thank Bruce Boyd, Teachers Insurance Annuity Association/College Retirement Equities Fund, and Susan Morisato, Bankers Life and Casualty, for reviewing drafts and offering invaluable comments and suggestions.

Executive Summary

As policy makers continue to debate how the nation should pay for long-term care, the private long-term care insurance market continues to expand to offer Americans a solution to the financing problem. As of mid-1990, more than 130 companies sold long-term care insurance, a 79 percent increase from 1987. Moreover, the number of policies sold has doubled in the last two and one-half years from 815,000 in December 1987 to more than 1.65 million in June 1990.

Most importantly, the products themselves continue to improve in response to market pressures and the demands of regulatory agencies. An analysis of the policies sold by the 15 companies that represented 75 percent of the market in 1989 found:

- All but one plan offered nursing home and home health care. Seven also provided an adult day care benefit.
- Eligibility for nursing home care usually was based on physician certification of need; only one plan required a prior hospital stay. Two plans considered limitations in activities of daily living.
- Most plans (13) offered four or more years of nursing home coverage. One-third offered an unlimited lifetime benefit.
- All but one plan was sold to persons up to age 84.
- Most plans (13) offered an inflation protection feature. Four plans were sold only with an inflation protection feature.
- All the plans were guaranteed renewable.
- All but one plan gave consumers a 30-day free look. (One company provided a 10- or 30-day free look depending on state requirements.)

Although the market is still dominated by products sold individually to an older population, newer vehicles, such as employer-sponsored arrangements and coverage under life insurance plans, have grown rapidly since their recent introduction in the marketplace. The number of people covered under employer-sponsored plans, including retirees and parents, quadrupled over an 18-month period, from 20,000 in December 1988 to almost 80,000 in mid-1990. During this same period, the number of people purchasing coverage as part of a life insurance contract increased from about 1,000 to more than 14,000. As diverse products aimed at younger consumers take hold, the products sold individually to older people will occupy a smaller share of the market.

Although new and relatively small, the long-term care insurance market appears to be strong and growing at a steady pace. This trend, combined with budgetary pressures faced by state and federal governments and an ever-growing aging population, suggests that the insurance industry will play a significant role in paying the nation's long-term care bill.

Long-Term Care Insurance: A Market Update

The number of long-term care insurance policies that have been sold to the American public has continued to grow at the rate of about 35 percent a year since 1987. (See Figure 1, page 5.) As of June 1990, more than 1.65 million policies had been purchased. The lower growth rate during the first part of 1990 can be attributed solely to one insurer that withdrew from the market. Although the insurer will continue to maintain its policies in force, these policies are not reflected in the figures presented here.

Long-term care insurance policies fall into four categories–individual, group association, employer-sponsored and coverage available with life insurance policies. The greatest number of policies sold have been to individuals and through group associations; their growth has been fairly steady over the past 3 years. (See Figure 2, page 6.) In contrast, the employer and life insurance markets have just begun to surge. The number of persons who have purchased a policy under an employer-sponsored arrangement grew from about 20,000 to

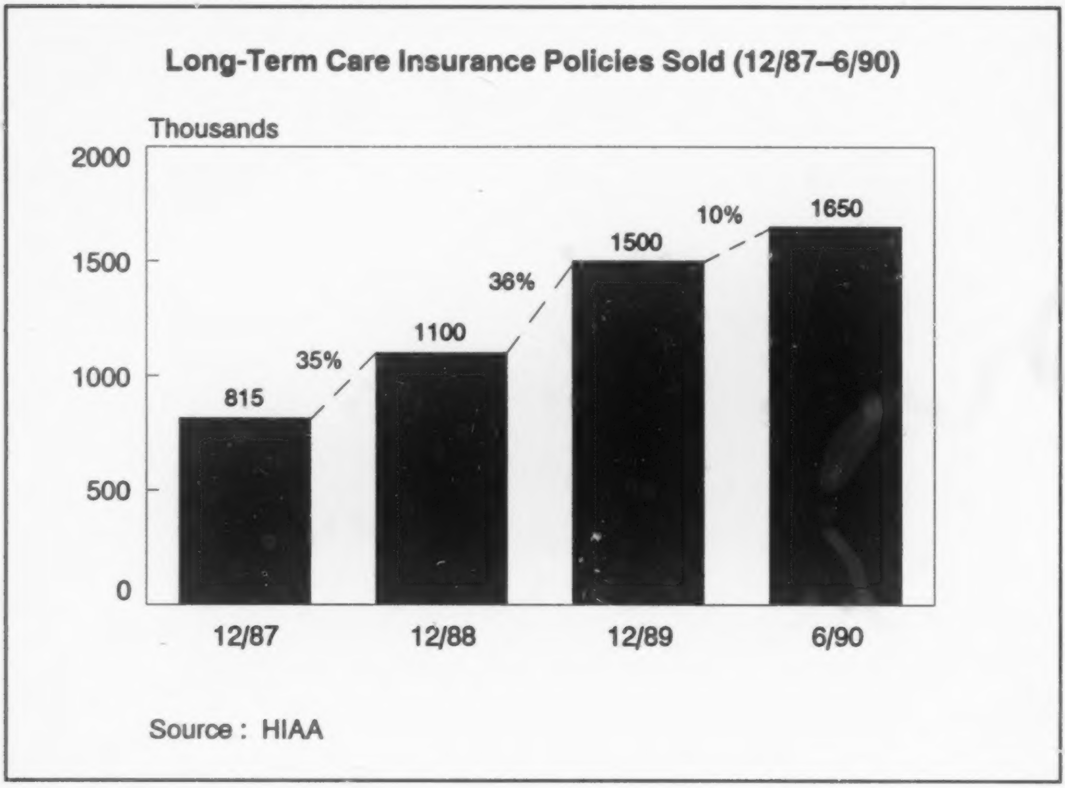
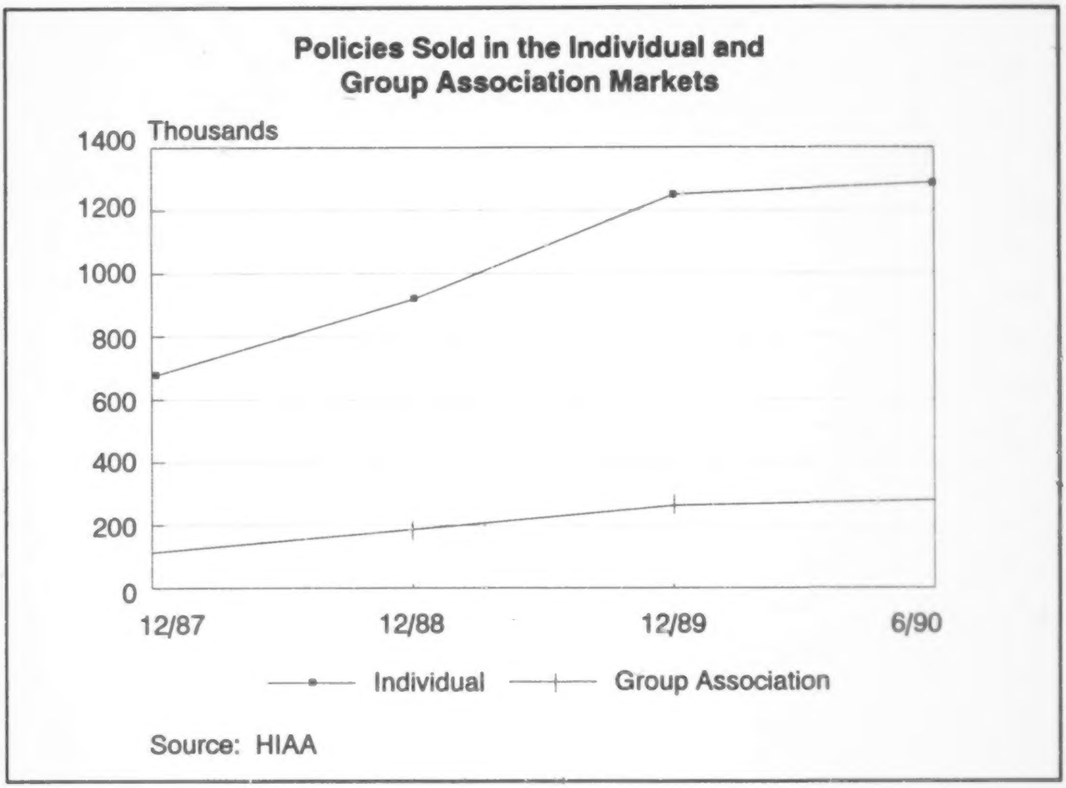


Figure 1

almost 80,000 during the past 18 months. During the same period, the number of persons purchasing long-term care coverage available with life insurance grew from 1,000 to more than 14,000. (See Figure 3, page 7.)

The number of companies selling a long-term care insurance policy also has grown at a steady pace since 1987. At that time, HIAA identified 75 companies selling a policy that met the minimum definition of long-term care insurance as contained in the model statute developed by the National Association of Insurance Commissioners (NAIC).[1] As of June 1990, 134 insurers sold such a policy, representing an increase of 13 percent from the previous 6 months. The largest growth occurred between 1987 and 1988 when 30 new companies entered the long-term care market. (See Figure 4, page 8.) (Appendix A presents a list of all companies selling long-term care insurance as of June 1990.)



Source: HIAA

Figure 2

In addition to the one insurer that stopped selling long-term care insurance during 1990, 19 companies withdrew from the market between 1987 and 1989. Collectively, these 20 companies had sold more than 130,000 policies. Although these companies continue to maintain their policies in force, they also are excluded from the figures presented here.

Long-term care insurance began to play an important role in the market in 1985 and 1986, when the number of companies entering the marketplace doubled from previous years. (See Figure 5, page 9.) Most of the growth since 1988 can be attributed to the market entry of Blue Cross and Blue Shield plans and to insurers selling coverage connected with life insurance policies. (Appendixes B and C list Blue Cross and Blue Shield long-term care plans and companies offering long-term care coverage as part of a life insurance contract as of June 1990.)

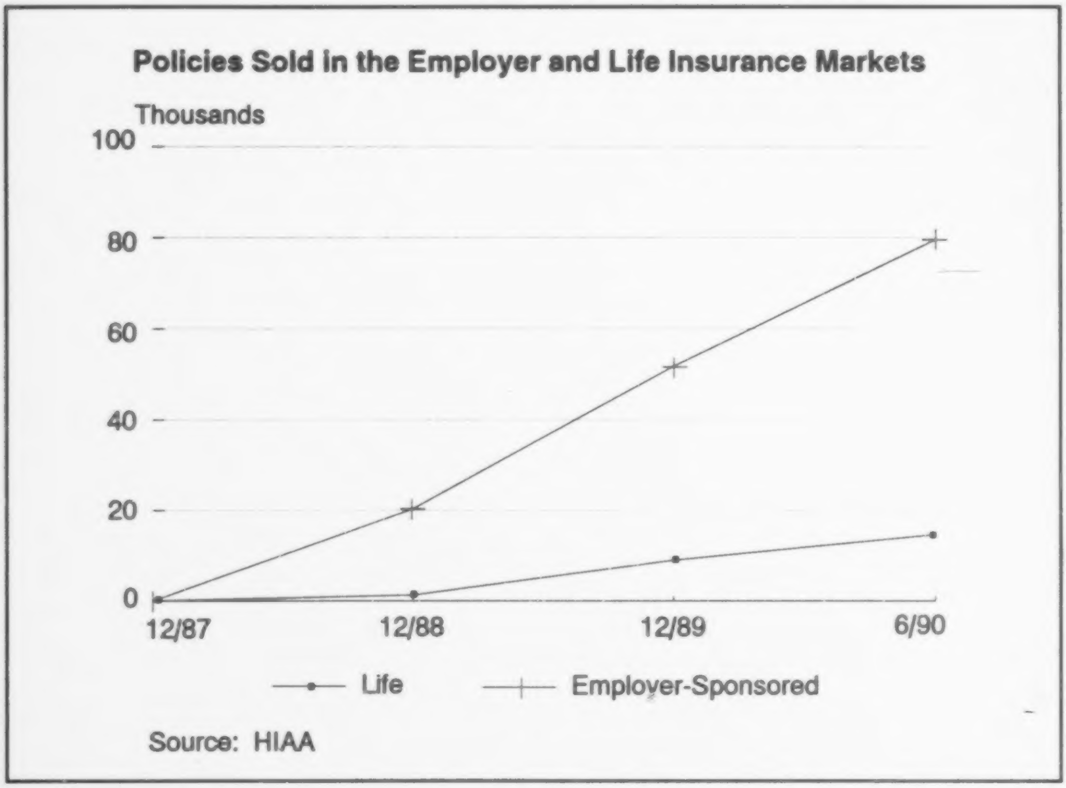
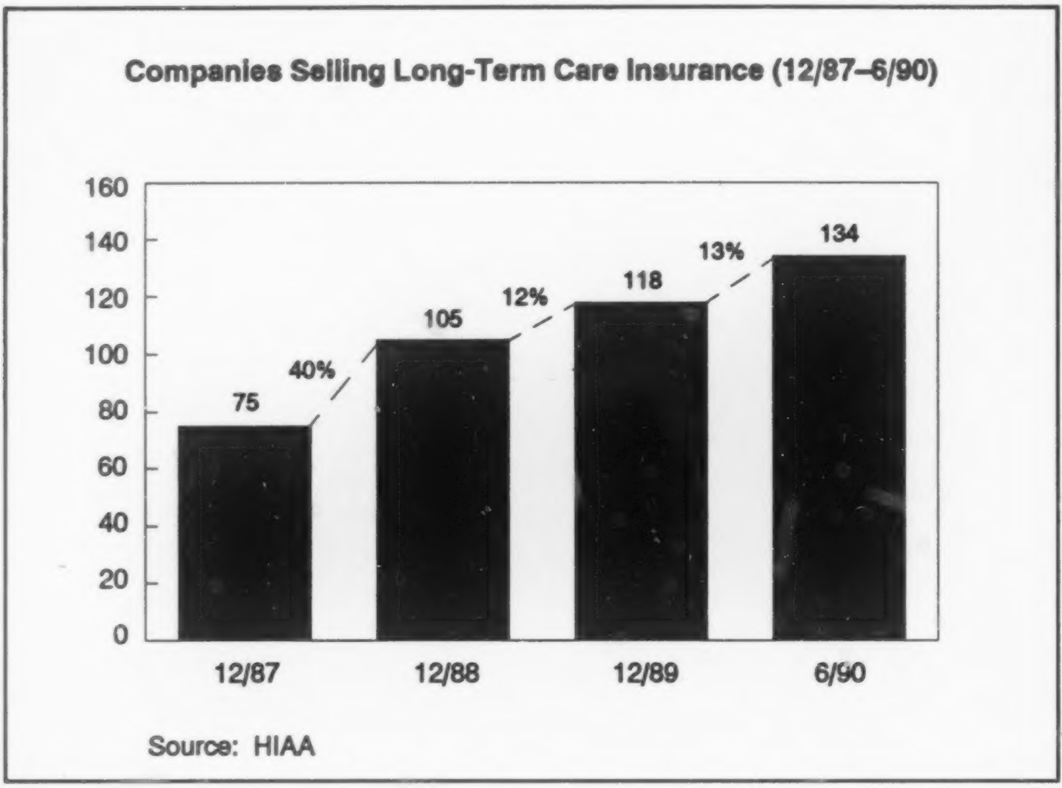


Figure 3

As of June 1990, about three-fourths of all insurers sold individual or group association policies covering 94 percent of the 1.65 million persons who had bought a long-term care policy. (See Table 1, page 10.) The average purchase age of persons buying individual plans was 72, while the average age of persons buying group association plans was 69.

Only 10 insurers sold coverage to employer-sponsored groups, and 5 percent of all purchasers were covered under such arrangements. The number of employers providing long-term care insurance, however, has grown exponentially since 1987 when two employers first offered the benefit. (See Figure 6, page 11.) By mid-1990, a total of 153 employers offered or were about to offer a plan; almost two-thirds of these plans are to take effect in 1990 or 1991. The average age of employees electing the benefit was 43.



Source: HIAA

Figure 4

Long-term care coverage available through life insurance policies represented about one-fifth of insurers selling long-term care and only 1 percent of persons covered. (These figures do not include accelerated death benefit policies that advance the death benefit in the event of terminal illness or a specified disease.) As part of a life insurance plan, long-term care coverage typically is added as a rider using the policy's life insurance values to provide for long-term care expenses. A typical rider pays 2 percent of the death benefit each month, up to 50 percent of its total value, if long-term care services are needed prior to death. If a person has a life policy for $100,000, for example, $50,000 could be dispersed for long-term care under this arrangement. When adjusted to reflect each insurer's share of the market, the average face value of life insurance plans purchased with long-term care coverage is $68,855 although it ranged from $30,000 to $119,535 by insurer. The average age of persons purchasing this type of coverage was 48.

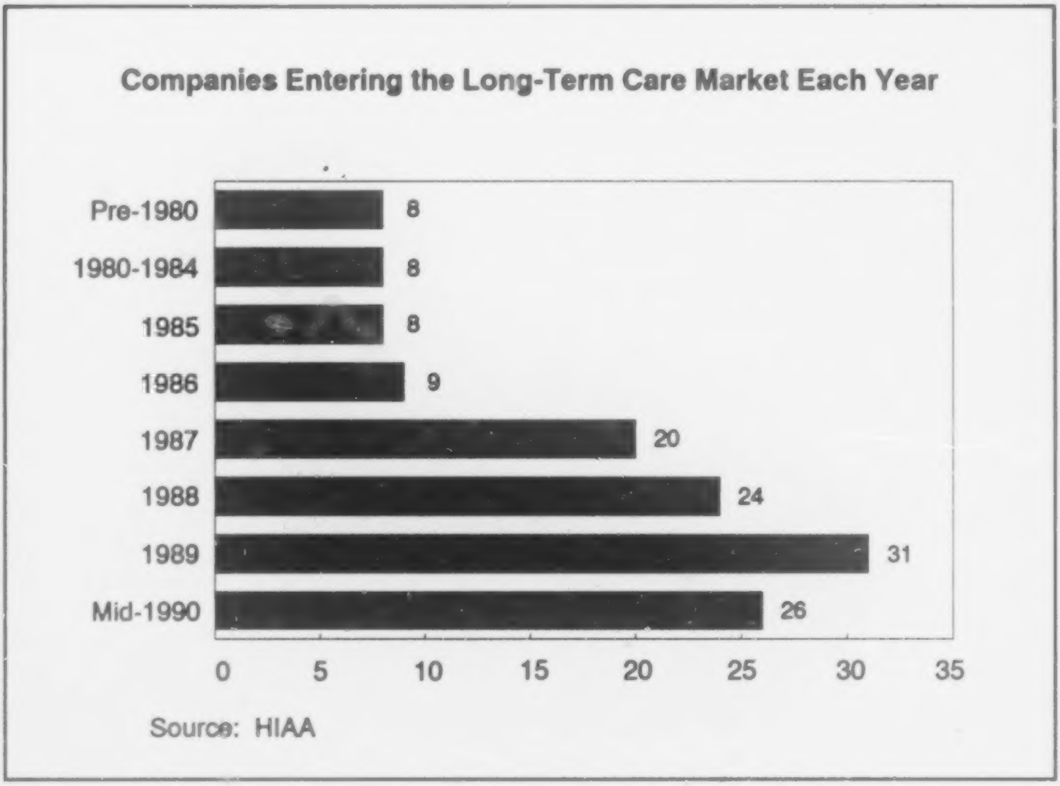


Figure 5

At least five insurers underwrite coverage for members of continuing care retirement communities (CCRCs.) Under these arrangements, CCRCs that do not include the cost of long-term care services within their entry fees or monthly charges offer their members long-term care protection through an independent insurer.

As of June 1990, at least 150 CCRCs had contracted with an insurer to provide long-term care insurance. Of the total, about 100 had already implemented a plan. When coverage had been optional, between 5 percent and 50 percent of the residents in each CCRC elected to purchase the coverage. Reflecting the older age of CCRC residents generally, the average age of residents buying a long-term care plan was 79.

Best's Insurance Reports, Life-Health, 1990, a financial rating of companies selling long-term care insurance, indicates that about two-thirds had a rating of A or A+. The majority of companies (54) had a superior or A+ rating. *Best's* evaluates both

Table 1

Long-Term Care Products by Percentage of Companies, Policies Sold, and Average Age

LTC Product*	Percentage of Companies**	Percentage of Policies Sold	Average Age
	N=134	N=1.65 million	
Individual	60.5	77	72
Group association	15.0	17	69
Employer-sponsored	7.5	5	43
LTC as part of life policy	21.0	1	48

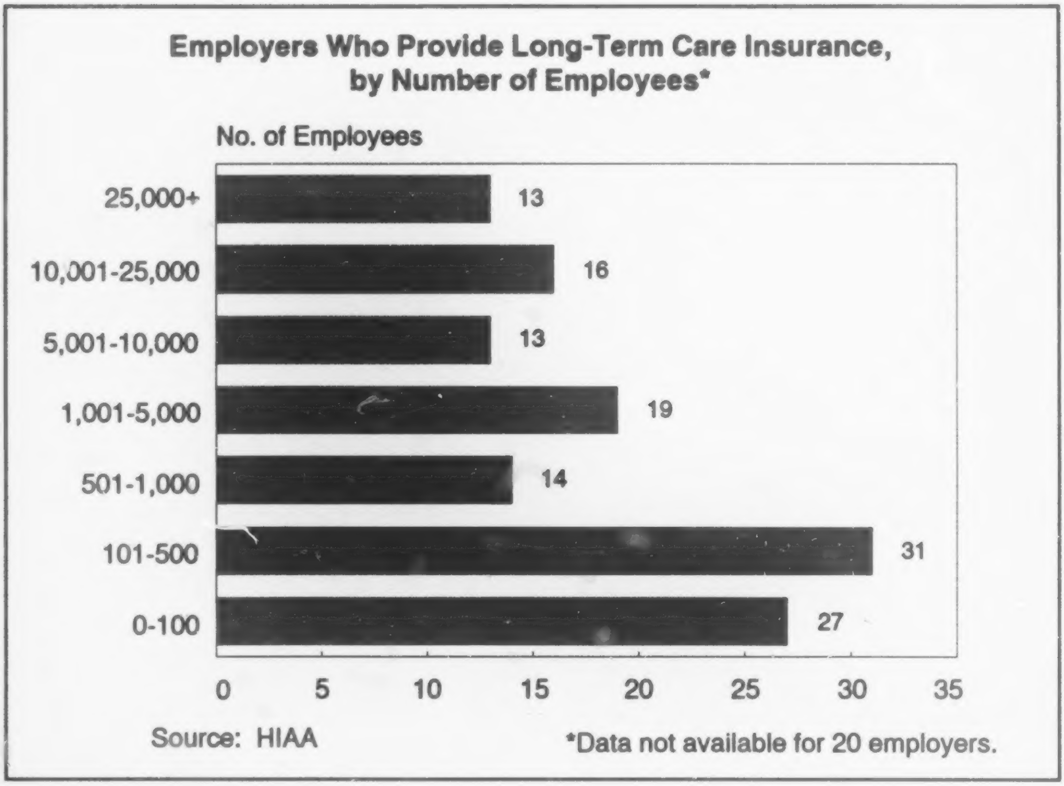
Source: HIAA 1990

* Does not include information on continuing care retirement communities.

** Does not total 100 percent because five companies sold an individual policy and another form of coverage.

quantitative and qualitative data on each company to determine its ability to meet contractual obligations. Most of the remaining companies had a rating between A- and B. Another 17 percent either had a rating of C or lower, were rated below minimum standards, requested that their rating not be published or were not rated because of their relatively small financial holdings, insufficient experience or significant changes to their organization. (As a point of comparison, 56 percent of all 1,380 companies reported in Best's Insurance Reports were assigned a rating. The remaining 44 percent were not rated.) (See Table 2, page 12.)

In another measure of financial stability, half of the companies had financial holdings totaling $25 million to $750 million and one-third had reserves between $1 million and $25 million. About 3 percent were in the top financial category with holdings of $2 billion or more. This rating is based on the company's reported policyholders' surplus plus conditional or technical reserves treated as liabilities. (See Table 3, page 13.)



Employers Who Provide Long-Term Care Insurance, by Number of Employees*

Source: HIAA

*Data not available for 20 employers.

Figure 6

Leading Sellers of Long-Term Care

More than three-fourths of all long-term care policies sold as of the close of 1989 were sold by 15 companies. Because these companies represent a major portion of the market, their most recently issued policies (as of early 1990) were analyzed to determine the status of the marketplace.

Most of the 15 companies had been in the market a relatively long time. Six began selling prior to 1980, another seven between 1980 and 1984 and only two since 1985. About half had a 1990 *Best's* rating of A or A+. Another six companies were rated B or B+. Of the remaining two companies, one company had a C rating and one was not rated by *Best's*.

Table 2

A.M. Best's Financial Rating of Long-Term Care Insurers

Rating	Percentage of Companies N=112*
A or A+	65.2
A- to B	17.9
C+ to C-	2.7
NA**	9.8
Other***	4.4
TOTAL	100.0

Source: *Best's Insurance Reports, Life-Health*,1990

* Excludes Blue Cross and Blue Shield plans.

** Not rated due to size, insufficient experience, or inapplicable (due to the nature of the company's business) rating procedure.

***Below minimum standards, or not published at company request.

◆ Services Covered

Of the typical benefits that the leading long-term care insurance sellers provided in early 1990, all but one offered coverage of nursing home and home health care. In five cases, however, home health care was offered as a rider. Seven plans contained an additional adult day care benefit and two provided a respite benefit. Only one plan provided just nursing home care.

◆ Eligibility for Benefits

Only one plan based nursing home benefit eligibility upon a prior stay in a hospital. Most (12) required a physician certification of need and medically necessary care to qualify for nursing home admission. The other two based eligibility on needing assistance in activities of daily living (ADLs). ADLs are considered the basic tasks of everyday living. Numerous studies have shown that ADLs are significant predictors of admission to a nursing home, use of home care, use of hospital services, living arrangements, overall Medicare expenditures,

Table 3

Company Financial Size as Reported by A.M. Best*

Size (in $ millions)	**Percentage of Companies** N=112**
2,000 +	2.7
1,000-2,000	3.6
750-1,000	3.6
25-750	50.9
1-25	33.0
NA***	6.2
TOTAL	100.0

Source: *Best's Insurance Reports, Life-Health*,1990

* Based on reported policyholders' surplus plus conditional or technical reserves treated as liabilities by the companies.

** Excludes Blue Cross and Blue Shield plans.

*** Not rated due to size, insufficient experience, or the rating procedure is inapplicable to the nature of the company's business.

insurance coverage and mortality.[2] In one plan, nursing home benefits were triggered by assistance needed in three out of six ADLs and in another case, two out of five ADLs.

In response to regulatory and market pressures, companies have continued to eliminate their prior hospital stay requirements. Since December 1988, the NAIC model act has prohibited insurers from requiring prior hospital stays in order for a policyholder to qualify for long-term care benefits. Prior to 1988, 25 out of 29 HIAA member companies required such a stay before a policyholder could become eligible for nursing home coverage.[3] Only one plan introduced in 1988 by an HIAA member, however, had this restriction and only one of the top-selling companies in the market contained this gatekeeping mechanism in 1989.

Of the 14 plans offering a home health benefit, most did not require a prior stay in an institution. As with nursing home care, eligibility generally was based on physician certification and medical necessity. One plan required that a policyholder need assistance in two out of six ADLs. The remaining plans required a prior stay in a nursing home before home health benefits were covered. In June 1989 and December 1989, the NAIC model act was amended to prohibit the use of prior nursing home stays in order to qualify for home health care benefits. As with the NAIC prohibition against the use of prior hospital stays, it is expected that companies will respond and adapt to this latest NAIC provision.

◆ Maximum Coverage Periods

There were separate maximum coverage periods for nursing home and home health care in 12 plans. Five plans offered unlimited lifetime coverage. Another five plans offered between four and ten years of coverage. Two offered two or three years of coverage.

Of the 14 plans that offered a home health benefit, all but three set a separate maximum benefit period. Six provided two to five years of coverage and five provided one year or less of coverage. For three of the 15 plans, the policy maximum for nursing home and home health care benefits was combined. All three offered a choice in the number of years of coverage, including an unlimited lifetime benefit. For all 15 plans, the maximum benefit periods greatly exceeded the one year minimum specified in the NAIC model act. In all but two plans, the policy maximum was four or more years, a standard recently recommended in a study conducted on behalf of the American Association of Retired Persons.[4]

◆ Age Limits

In a significant departure from the past, all but one of the 15 plans were sold to persons up through age 84 and two plans were sold to persons up through age 89. (One plan limited coverage to one year for persons between the ages of 80 to 84.) Previous HIAA surveys found that 79 was generally the maximum age possible for purchasing a long-term care plan.[5] The minimum purchase age for most plans is 50.

◆ Inflation Protection

Most of the largest sellers offered policyholders a plan that would increase their benefit amounts over time to help keep pace with anticipated long-term care costs. The extensive availability of this option is a major change from the earlier long-term care market. As reported in previous HIAA research, prior to 1988, only one-fifth of HIAA member companies selling long-term care insurance offered plans with an inflation protection feature. In 1988, 10 out of 14 new plans introduced by HIAA member companies contained such a feature.[6] By 1989, all but two of the top 15 companies in the long-term care market included an inflation feature.

Nine of the 15 plans offered an inflation protection feature as an option and four plans were sold only with an inflation adjustment. All but one plan increased the daily indemnity initially purchased at a rate of 5 percent a year. In almost all cases, the indemnity could be increased for a specified period of time, generally 10 or 15 years. Only two plans increased the benefit over the policyholder's lifetime with no time limit. The additional cost of the inflation feature usually was built into the level premium at the time of purchase. In two cases, the cost of the inflation feature was added to the initial premium over time.

As is true of other product improvements, the recent addition of inflation protection features exemplifies industry responsiveness to regulatory concerns and requirements. In December 1989, the NAIC amended the model regulation to require an optional inflation protection feature as part of a long-term care insurance plan. Although this amendment is expected to be modified as regulators and insurers reach consensus on how best to balance affordability and protection, it is most likely that some form of inflation protection will be a required option in all future policies.

◆ Deductible Periods

All 15 insurers offered a choice of deductible periods which ranged from 0 to 365 days. Generally, the shorter the deductible period, the higher the premium. Most companies (12) offered a plan that pays benefits from the first day the policyholder meets the eligibility requirements. The longest deductible period offered by most companies was 90 or 100 days.

◆ Renewability

As required by the NAIC model regulation, all 15 companies sold policies that could not be canceled unless the policyholder discontinued payment of premiums. Premiums could be increased if they were increased for everyone in a policyholder's "class," a term generally defined by the state.

◆ Preexisting Conditions

Preexisting condition exclusions prevent coverage of medical conditions that are diagnosed or treated within a specified time immediately prior to and following commencement of the policy. This common underwriting tool is a primary method for controlling adverse selection, unexpected utilization, and premiums. For the leading long-term care sellers, the preexisting condition exclusions were limited generally to the requirements of the NAIC model act. Prior research found longer and more variable time periods during which preexisting conditions were not covered.[7]

The NAIC model act calls for a preexisting condition exclusion from coverage not to exceed six months before and after the effective date of the policy. Twelve of the top-selling policies followed this standard. In a new development, two insurers did not have preexisting condition exclusions. One insurer excluded coverage for preexisting conditions for two years prior to the effective date of the policy, although it has since changed it to 6 months. (See Table 4, page 17, for a summary of typical coverage provided by the leading sellers.)

Table 4

Typical Coverage Offered by Leading Sellers*

Services covered:	◆ Skilled, intermediate and custodial nursing home care ◆ Home health care ◆ Adult day care (often)
Daily benefit:	◆ $40-120/day nursing home ◆ $20-60/day home health care
Benefit eligibility:	◆ Physician certification/ medically necessary
Maximum benefit period:	◆ 5 years or unlimited
Alzheimer's disease coverage:	◆ Yes
Deductible periods:	◆ 0-20 and 90-100 days
Renewability:	◆ Guaranteed
Preexisting condition:	◆ 6 months
Inflation consideration:	◆ Yes
Age limits for purchasing:	◆ 50-84
Waiver of premium:	◆ Yes
Free-look period:	◆ 30 days
Marketing:	◆ Company or independent agents

Source: HIAA 1990

* Based on 15 plans representing 75 percent of the market

◆ Premiums

Premiums for a plan paying $80 a day for nursing home care, and $40 a day for home health care with a 20-day deductible period and a four year maximum coverage period for nursing home care, have been compared with and without an inflation protection feature. (See Table 5, page 18.) Most plans (11) offered a policy without an inflation protection feature. For the nine that reported premium data, the average annual premium at age 50 was $483. At age 65, it was $1,135 a year, and at age 79, it was $3,841 a year.

When inflation protection features were considered, premiums increased substantially at lower ages. For the 12 plans

Table 5

Average Annual Premiums for Leading Long-Term Care Policies*

Age	Without Inflation N = 9**	With Inflation N = 12***	Percent Difference
50	$483	$658	36
65	$1,135	$1,395	23
79	$3,841	$4,199	9

Source: HIAA 1990

* Generally, for a plan providing $80 per day for nursing home care, a 20-day deductible period and four years of coverage.

** Four plans were not sold without an inflation adjustment feature and two plans did not provide premium data.

***Two plans did not provide an inflation adjustment feature and one plan did not provide premium data.

that reported premium data, the average annual premium at age 50 was 36 percent higher ($658), while at age 79, it was only 9 percent higher ($4,199) with an inflation protection feature.

All but one of the companies gave policyholders a 30-day free-look period during which time they could cancel coverage for any reason and receive a premium refund. The other company provided either a 10-day or 30-day period, depending on the state requirement.

Growing Employer Market

As of December 1989, employer-sponsored plans available from nine insurers covered all levels of nursing home care, home health care and adult day care. Two also provided a respite benefit for family members and two paid benefits if policyholders became disabled and remained at home, regardless of whether paid noninstitutional services were used. The plans were offered to employees and their spouses, retirees and their spouses, and the parents and parents-in-law of the

Table 6

ADLs Used in Employer-Sponsored Plans

ADL Limitation	Plans (N=8*)
Using the Toilet	8
Eating	8
Dressing	7
Transferring	6
Mobility	5
Maintaining Continence	3
Cognitive Impairment**	3
Taking Medications**	2

Source: HIAA 1989

* Data missing for one plan.

** Related to, but not considered to be an activity of daily living (ADL).

employee. The choice of nursing home benefit amounts ranged from $60 to $100 a day and half that amount for community-based benefits. Two plans paid 80 percent of actual provider charges up to the daily maximum amount selected.

Eligibility for benefits was triggered by becoming disabled in a specified number of ADLs. Limitations in using the toilet and eating unaided were the two most frequently used ADLs. Limitations in dressing, transferring and mobility were also common. A small number of plans recognized the inability to take medicine unaided and the inability to perform ADLs due to cognitive impairment as appropriate criteria for benefits. (See Table 6.) One plan differentiated eligibility for noninstitutional benefits by requiring one less ADL limitation.

The lifetime benefit limit was expressed as a dollar maximum based on the indemnity amount purchased. In most cases, the maximum was equal to four or five years if only nursing home benefits were used, eight or ten years if only home health benefits were used, or somewhere in between these time periods if a combination was used. One plan had a maximum benefit period of five years each for nursing home and home health care. Another plan offered an optional unlimited lifetime benefit.

The deductible periods ranged from 20 to 100 days, although four plans offered only a 90-day deductible. Three of the plans had a shorter deductible period for home health care. Because the plans had been designed for the employee to pay the full premium, coverage could be continued through direct billing of an individual if employment was terminated.

Four of the nine employer-based plans offered a return-of-premium or a reduced paid-up option; one offered both. While these options increased premiums substantially (because reserves must be higher than the amount needed to pay expected claims), these options guaranteed that employees who contributed to a plan would receive some benefit.

Under the return-of-premium option, policyholders in one plan could have received 25 percent of their premium if they died or terminated the policy after participating for five to nine years and up to 100 percent of their premium after 20 years. A second insurer gave policyholders 50 percent of their premium if they terminated the plan or died after a minimum premium payment period of 10 years. Another insurer offered a more limited, although less expensive option, whereby premiums were returned only in the event of death. If death occurred after retirement, the amount of premium returned was reduced 10 percent a year from the point of retirement.

Under the reduced paid-up option, one insurer paid 30 percent of the daily benefit if a policyholder terminated a plan after 10 years and received up to 75 percent of the benefit after 25 years. In the other case, policyholders at age 65 or a minimum premium payment period of 10 years (whichever was later) could have received 50 percent of the benefit if they terminated coverage and qualified for care.

As with all individual plans, the premiums were level and based on age at the time of purchase. Generally, the premium covered $80 a day for nursing home care, provided five years

Table 7

Average Annual Premium at Selected Ages for Group Plans*

Age	Annual Premium Amount**
30	125
40	176
50	328
65	1,108
79-80	4,438

Source: HIAA 1989

* Generally, for a plan providing $80 per day for nursing home care, a 90-day deductible period and five years of nursing home coverage

** Includes data from six insurers for ages 30 and 40, and seven insurers for ages 50, 65 and 79/80. Premium data are missing for two insurers

of coverage and had a 90-day deductible period. At age 30, premiums averaged $125 a year, or about $10.50 a month. At age 40, close to the average age of employees actually purchasing coverage, premiums averaged $176 a year, or about $15 a month. At age 79 or 80, annual premiums for retirees and parents averaged about $4,438 a year. The range was greatest at this age, spanning from a low of $2,902 to a high of $7,014 a year. (See Table 7.)

None of the premiums reported included the additional cost of an inflation or a nonforfeiture feature. (See Table 7.) In five of the nine plans, benefit upgrades were offered periodically after purchase. For example, a $10 or $20 increase in the daily benefit would be offered to the policyholder every five years. Policyholders could purchase this additional coverage without evidence of insurability. Premiums for the additional benefit amount would be based on the policyholder's age at the time the additional benefit was purchased. Policyholders could also purchase additional coverage in those years between such offerings but would be subject to underwriting during those times.

Four of the nine plans offered an optional built-in inflation adjustment. Generally, the initial daily amount purchased increased 5 percent annually for a specific period of time, such as 20 years. For example, a $100 a day benefit would increase to $125 after 5 years and to $150 after 10 years. The initial level premium included the cost of this option.

◆ Enrollment Experience

Since the first plan was introduced in 1987, the employer-based long-term care market has grown rapidly. By mid-1990, 153 employers had agreed to offer a long-term care insurance plan to their employees; 54 plans became effective in 1989 and the remaining 99 were scheduled to become effective in 1990 or 1991. Ten insurance companies had sold the 153 plans, ranging from one company having sold 65 plans to two companies having sold one plan each. The median number of employer plans sold by each insurer was 10. (See Exhibit 1 for a partial list of employers who have offered such coverage.)

Employers of all sizes have offered their employees a long-term care benefit. (See Figure 7, page 24.) Two insurers had sold almost all of their business to employers with 500 or fewer employees; eight insurance companies had sold almost all of their business to employers with at least 1,000 employees.

Across the 105 plans with enrollment experience, almost 700,000 employees were offered a long-term care insurance plan as of mid-1990. In almost every case, the plan was offered to employees and their spouses, retirees and their spouses, and the parents and parents-in-law of the employee. For the seven insurers reporting data across all their employer plans, the average age of employees electing the benefit ranged from 39 to 58, the average age being 43.

As of June 1990, about 79,500 persons were enrolled in employer-sponsored long-term care plans; about 60 percent were active employees and their spouses; the other 40 percent were retirees and their spouses, parents and parents-in-law. For the employee pay-all plans, employee participation ranged

Exhibit 1

Partial List of Employers Offering Long-Term Care Insurance (1990)*

Aetna Life & Casualty Company
Alaska, State of
American Council of Life Insurance
American Express Company
Army and Air Force Exchange Service
Argonne National Laboratory
Ball Corporation
Bell Atlantic Corporation
Bell South
Bristol-Myers Squibb
Chevron
Continental Casualty Company (CNA)
First Interstate Bancorporation
Ford Motor Company**
General Foods Corporation
Harnischfeger Industries
Health Insurance Association of America
Household International, Inc.
IBM
Illinois, State of
John Hancock Mutual Life Insurance Company
Levitz Furniture
Maryland, State of
MERC
Metropolitan Life Insurance Company
Monsanto
Montefiore Medical Center
Nevada, State of
Northeast Utilities Service Company
Ohio State Teachers Retirement Systems
Professional Staff of Congress—City University of New York (PSC-CUNY)
Procter and Gamble Company
South Carolina State Retirement System
The Travelers Insurance Company
University of Southern California

Source: HIAA

*Although more than 150 employers were identified as providing a plan, only those listed above agreed to be identified.

**Two-Year Pilot Program.

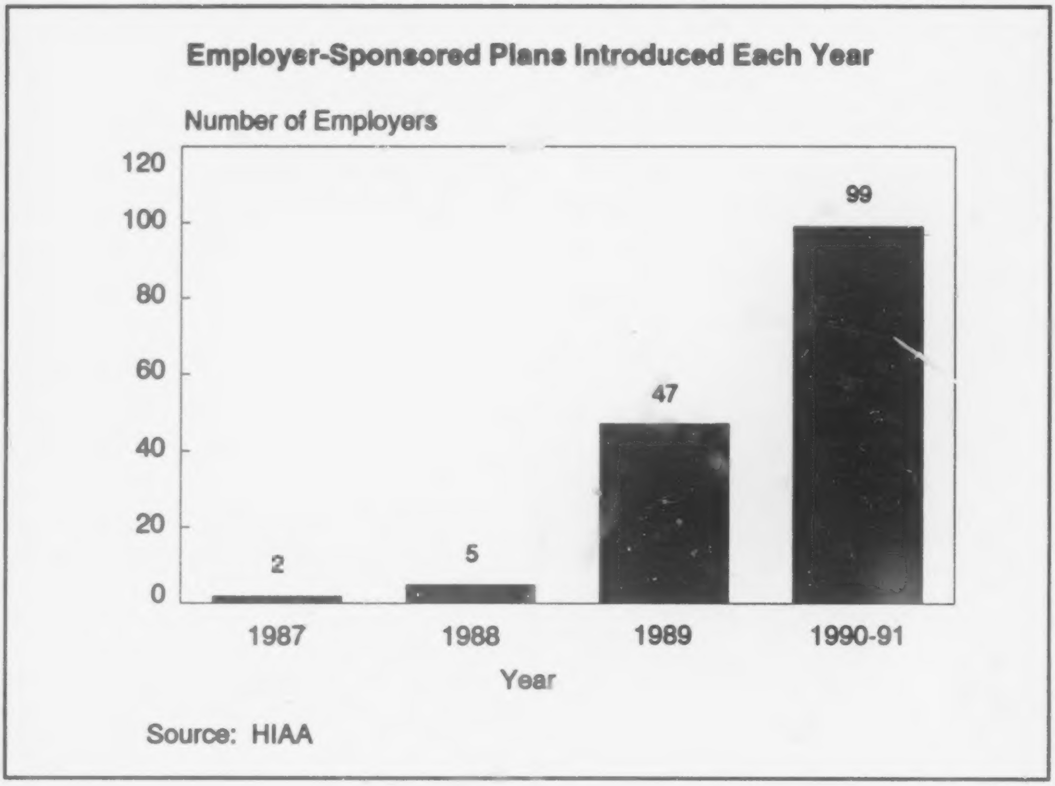


Figure 7

widely by insurer and by individual employer. At the high end, one insurer with 13 employer plans had an average participation rate of 13 percent. At the low end, one insurer with 54 plans had an average employee participation rate of 1.2 percent. By individual employer, employee participation ranged from a high of 37 percent to a low of 1 percent. The average percent of employees electing the benefit was about 5 percent.

For the first time, three employers contributed to the cost of the long-term care plan. In one case, the employer paid the entire premium for active employees although voluntary spousal coverage was paid by the employee. In the second case, the employer subsidized a revised retiree health plan that incorporated long-term care coverage and offered retirees a choice of the old or new plan.

More than half of the retirees elected the new health plan offering the long-term care coverage. In the last case, employees and retirees could draw on an employer-funded personal health account to pay for up to 20 percent of the annual long-term care premium.

In addition to these three employers, the Ford Motor Company began an employer-paid long-term care benefit on an experimental basis in 1989. As a two-year pilot program, it covers 4,800 active workers and 862 retirees in Louisville, Kentucky. If successful, the United Auto Workers union will propose that the program be implemented across the automobile industry. While all quite different, each of these arrangements represents a possible approach for future employer involvement in financing long-term care.

Long-Term Care Insurance Experience

HIAA conducted a mail survey of 33 member companies and their subsidiaries offering an individual or group association long-term care insurance plan in the summer of 1989. The purpose of the survey was to gather information on consumer preferences and the way plans are managed and administered by insurers. The survey included questions on plan options most frequently purchased, characteristics of buyers, underwriting practices and claims experience. Surveys were analyzed from 27 companies whose market penetration represented 45 percent of all policies sold as of June 1989. Because many companies had only recently entered the market, they were able to report only limited data in many cases. While adjustments for this were made where possible, the survey findings should be considered preliminary, given the minimal marketplace experience of most companies.

◆ Policy Options

Companies reported the policy options most frequently selected by policyholders of their most recently issued policy. (If a policy was so new that only limited data were available, however, companies reported on their older policy if they had one.)

Twenty-five companies reported policyholders most frequently selected daily nursing home benefit. Eight of these companies, representing 50 percent of the policies sold, reported that their policyholders most often purchased a $50-a-day nursing home benefit. Another nine companies reported that policyholders most frequently purchased daily benefits of $80 or $100 a day, representing another 25 percent of all policies sold by these 25 companies. Although the daily benefit choices ranged from $10 to $200, no company reported that its most frequently chosen daily option was less than $50 or more than $120 a day. Differences in the most frequently chosen benefit amount should be expected given the different geographic markets served by these companies. Twenty companies offered an optional deductible period which ranged from zero or 20 days, to 90 or 100 days. Two plans offered a deductible period of 365 days. The policyholders' overwhelming choice was a 15- or 20-day deductible period; 85 percent of all policies [illegible] by these 20 companies had this deductible period. Less than 10 percent of their policyholders chose a deductible period longer than 20 days and 7 percent chose a plan with no deductible. Four additional plans only offered one deductible period, generally 90 days.

Of the 25 companies that reported data on maximum benefit periods, 17 offered a choice; eight did not. For the 17 plans that offered a choice of benefit periods, most offered a minimum benefit period of one, two, or three years. At the other end, most offered a maximum benefit period of five years or an unlimited lifetime benefit. The most commonly selected maximum benefit period was five years, which represented more than one-third of all policies sold by the 17 companies offering a choice. One-quarter chose an unlimited lifetime benefit and another one-quarter chose a three-year benefit. Less than 2 percent of policyholders chose a benefit period of two years or less. For the eight plans that only offered one maximum benefit period, most offered four or five years of coverage.

Fifteen of the 27 companies offered a plan with an inflation protection feature; four plans were sold only with *built-in infla-*

tion protection. For the 11 plans in which inflation protection was an optional feature, between 12 percent and 87 percent of policyholders elected to purchase the option. On average, about one-fourth of the policies sold by these 11 insurers included inflation protection. (This estimate understates the percentage of consumers who opt for inflation protection, however, because it is based on the total number of policies sold by each company—this includes an unknown number of policies sold by insurers before they offered an inflation protection feature.)

◆ Marketing

Company agents and/or independent agents and brokers sold the majority of policies. Three plans were sold by direct response only and four plans were sold by financial planners as well as agents. The survey also asked about agent commission rates for the first through fifth years and thereafter. First year commission rates for the 23 companies reporting data ranged from 10 percent to 60 percent. The average first year commission rate was 36 percent for those companies that had sold one-third of all policies as of June 1989.

Because commission rates may cover different expenses, it is difficult to interpret these rates. For example, an agent employed exclusively by one company may receive the entire first year commission for the sale of a long-term care insurance policy. Independent agents, who may earn higher commission rates, however, may receive only a part of the total commission. The rest of the commission may cover overhead, such as office space and management and support staff salaries. Therefore, depending on how the policy was sold, it cannot be assumed that the selling agent received the entire commission.

The average second year commission rate was 11 percent, ranging from 4 percent to 20 percent. The average rate for the third through fifth year was 9 percent. After five years, the average was 7 percent. Five companies limited the time during which a commission was paid although they may have paid agents service fees thereafter. Commission rates were limited to two years for one policy, five years for two policies and 10 years for another two policies. Three companies paid lower commission rates for policies sold to persons above a specified age. Commission rates were 10 percentage to 20 percentage points lower if sold to persons above certain ages, ranging from 65 to 80.

Companies also were asked if they provided consumers with an outline of the policy's benefits at the initial point of sale so that consumers could compare plans across several policy features. All companies that relied primarily on agents reported that they provided an outline of coverage at the point of sale. All but two outlines conformed to the requirements of the NAIC model regulation as amended in December 1988. The model regulation specifies which policy features must be described in the outline and the order and format in which they must be presented. The three companies that sold direct response products did not provide an outline of coverage at the point of sale but were not required to do so by the NAIC model regulation. (The model regulation requires that companies selling policies through the mail provide the outline of coverage at time of policy delivery.)

Companies were asked what percentage of approved policies were returned by the policyholder before the expiration of the free-look period, generally lasting 30 days. On average, 10 percent were returned during the free-look period for a premium refund and cancellation of the policy among 21 companies (or 40 percent of the marketplace.) By company, the figure ranged from 1 percent to 25 percent.

For those companies comprising 45 percent of the market, 62 percent of their policies had been purchased by women. By company, the figure ranged from 40 percent to 73 percent women. An average of 57 percent of all policies purchased from companies comprising 35 percent of the market were purchased by married people. Ten of the 17 companies responding to the question discounted a spousal premium 10 percent to 15 percent. Two insurers, however, offered substantial premium reductions for married couples. In one case, policyholders paid only the premium of the older spouse and in another case, the second spouse paid only 5 percent of the premium. Not surprisingly, a high percentage of policyholders of both plans were married (80 percent and 95 percent, respectively.) A third company offered a substantial discount, averaging 60 percent, to individuals who did not live alone.

Companies also were asked the rate at which policyholders voluntarily terminated their long-term care plans (i.e., lapse rates.) Fifteen companies, representing about one-third of the market, reported an average first-year lapse rate of 18 percent and an overall lapse rate, including the first year, of 16 percent. (These figures excluded lapses due to death except in two cases.) Lapse rates ranged widely from 4 percent to 50 percent and did not change when four companies with only one year of experience were excluded from the analysis. Companies selling the product for several years generally reported lower lapse rates. In addition, their overall lapse rates were much lower than their first year rates. As a means of comparison, the overall voluntary termination of ordinary life insurance policies in 1987 was 10.2 percent and for policies in-force less than two years, the average annual rate was 20.5 percent.[8]

It is difficult to determine the validity of the lapse figures, given the number of companies responding, their varying years of experience in the market, and the wide range of figures reported. There are several reasons why policyholders may terminate their coverage, however. For example, given the rapidly changing nature of long-term care products, a policyholder who has an older, more restrictive plan, may cancel to buy a newer policy from the same or another company. (Changing policies generally would require a new application and commensurately higher premiums because of the older age.) Or, as with other purchases, policyholders may decide they no longer need or can no longer afford the product. Lapse rates appeared to be higher in companies who stopped active marketing of their long-term care plans or stopped selling such coverage altogether. Although these companies continue to maintain their policies in force, an individual holding such a policy may be more likely to cancel it or switch to another company.

◆ Underwriting

Companies were asked several questions about their underwriting procedures for all the long-term care policies they had sold to date. The percentage of all applications that were accepted for policy coverage ranged from 50 percent to 98 percent for the 23 companies reporting data. These companies represented about 40 percent of all policies sold as of June 1989. When weighted by the number of plans each company had sold, an average of 76 percent of all applicants were approved for coverage. Only four companies out of 27 reported that they also covered substandard risks for an additional premium.

Most companies, 22 out of 27, required an attending physician's statement either for all applications or under certain conditions. The most frequent reason for requesting it was age and/or the presence of a specific health condition. Additionally, 15 companies conducted a follow-up phone interview with every applicant or if the attending physician statement did not correspond to the application.

To obtain a better understanding of the underwriting process, the medical history section on the policy application form was analyzed for the 16 companies providing this information. These companies represented 35 percent of the market. One of the most commonly asked questions, related to prior nursing home and hospital use, was asked of 15 of the 16 insurers. The look-back period varied widely. Four insurers asked about confinement within the past year, two years or five years. (None of these insurers used all three of these time-related categories.) Two insurers asked about confinement within the past six months and one insurer asked about confinement within the past three years. One of these applications asked if there had been a confinement to a skilled nursing facility or rehabilitation facility rather than to a nursing home.

Fourteen of the 16 insurers asked if the applicant required assistance or needed supervision in everyday activities, generally ADLs. Twelve asked if this assistance is a current need, one insurer looked at assistance needed within the past six months, and one looked back at the past five years.

Table 8

Medical Conditions on Long-Term Care Insurance Applications, In Order of Frequency*

Condition	Number of Applications (N=16)
Alcoholism/liver disease/drug addiction	16
Alzheimer's disease/organic brain disease/senility	15
Cancer/leukemia/Hodgkin's disease	15
Heart attack, disorder, surgery	15
Diabetes	14
Lung disease/emphysema	14
Arthritis/osteoporosis/joint disease	14
Kidney disorder/dialysis	14
Stroke	11
Parkinson's disease	11
AIDS	10
High blood pressure	8
Amputation	6
Epilepsy/seizures	6
Multiple sclerosis	6
Paralysis	4

Source: HIAA 1989

* Conditions less frequently asked included: dizziness/fainting, eye disorders, weight loss, pernicious anemia, colitis, thyroid condition, hemophilia and prostate disease or disorders of the reproductive system.

All 16 companies asked applicants about the presence of several medical conditions. (See Table 8 for a summary of medical conditions included on the 16 application forms.) Generally, questions related to medical conditions sought information on past or present conditions for which medical attention was or is warranted. The look-back period ranged from currently having the condition to ever having had the condition. As indicated above, applicants reporting a condition were not automatically excluded from coverage in all cases because, in general, insurers sought further information about the reported medical conditions.

All 16 insurers asked about treatment for alcoholism, liver disease/cirrhosis, and drug addiction. Eleven asked about each condition within the past two or five years, although two insurers asked if treatment had ever been sought and one asked if cirrhosis was currently a condition.

Most insurers also asked about treatment for some form of cognitive impairment, cancer, and various heart problems and disorders. The look-back period was generally two or five years.

Most applications contained questions about diabetes; lung disease, such as emphysema; arthritis, osteoporosis or joint disease; and kidney disorders and/or dialysis. Five insurers also asked if the diabetic condition was insulin-dependent and one insurer had an additional questionnaire for those applicants answering yes to the general question on diabetes.

Less common, but still asked on at least half of the 16 applications, were questions about Parkinson's disease, AIDS, stroke and high blood pressure.

Twelve of the 16 companies also sought information on the use of various medical devices or appliances, including walkers, canes, catheters, oxygen, respirators, dialysis machines, wheelchairs and hospital beds. Two insurers asked only about wheelchair confinement. Seven insurers asked if the medical devices were being used currently and five insurers asked if they had been used anywhere from six months to five years prior to filing the application.

Seven of the 16 insurers asked the applicant about prescription drug use. Two asked about current use only, four asked about current use or use within the past 30 days to 12 months, and one insurer asked about drug use on a regular basis during the past five years. Six of the seven insurers asked for a list of the drugs and information related to their use. The seventh asked applicants to indicate the number rather than the type of drugs they were taking at the time of application.

Data were reported by 16 companies on the average underwriting cost per application for policies representing 30 percent of the market as of June 1989. Costs ranged from $5 to $100. When weighted by each company's share of the marketplace, the average underwriting cost was $55 per application.

Companies also were asked if they reinsured any part of the risk with another insurance company. Two-thirds of the responding companies did not; they represented 35 percent of the total market. Companies reporting they did reinsure some portion of their long-term care business represented 10 percent of the marketplace.

◆ Claims Experience

Because most companies began selling a policy in 1986 or later, most had little, if any, claims data to report. Fourteen companies, representing 38 percent of the market, reported a total of 5,733 submitted claims as of mid-1989. Generally, the longer a company had been selling a policy, the larger the number of claims they reported. As a result, it is likely that much of the claims experience reported in the survey was based on older policies with more limitations than those offered today. It is also likely that the experience reported represents "short-term" long-term care use. Claims experience for individuals receiving services over a long period of time is not available yet.

Only six companies reported receiving at least 25 claims; the average cost of a closed case was $9,744, although it ranged from $5,536 to $20,000. This average probably understates the cost of the average long-term care claim over the long run because most claims experience is relatively new. Available data on the cost of a closed claim generally represent the cost of covering nursing home patients with relatively short stays. Several more years of experience will be necessary before the average cost of covering all nursing home stays is available. Most of the claims dollars, 95 percent, covered nursing home care. Only 5 percent paid for home health care. This, too, indicates that current claims are filed for older policies covering primarily institutional benefits.

Considering only those companies reporting at least 25 claims, the median percentage of claims not approved for payment was 12 percent although it ranged widely from 0 percent to 62 percent. These figures represented claims, not individuals, that were denied payment, i.e., one individual could submit several claims that were denied. The most frequent reasons for denial were failing to meet the preexisting condition requirement, failing to meet the deductible period, misrepresentation or fraud on the application and inappropriate submissions (i.e., seeking Medicare supplement benefits). Among companies with the largest number of claims, the most common reason for claim denial was failing to meet the policy's deductible period. Most companies, 59 percent, reviewed claims monthly. Another 29 percent reviewed claims three or four times a year or reported that the time period varied.

Although findings from the HIAA member survey provide new information about the long-term care insurance market, the size of the sample and the variable company experiences in the market make it difficult to determine the validity of the information reported. It will be several years before a more complete picture of the total market is available.

Concluding Observations

Long-term care insurance is a young and evolving product that is continuing to gain wider recognition and acceptance. The number of policies sold, although relatively small by industry standards, is likely to continue to grow at an annual rate of about 35 percent. As early entrants into the market lose their historical advantage, the market will be distributed among more companies.

While individual sales continue to dominate the market, it will become a smaller percentage as diverse products aimed at a younger population gain hold. Products offering coverage under life insurance contracts nearly doubled in 1989 and although not addressed in this *Research Bulletin*, life insurance products that pay death benefits in the event of terminal illness or a specified disease also were introduced. While these policies do not specifically provide long-term care benefits, they offer a means for funding the cost of needed services.

The employer-sponsored market is expanding still, and during 1989 employers began contributing for the first time. Because group marketing reaches more people more quickly than does one-on-one marketing, persons covered under employer-sponsored arrangements could rapidly become a larger share of the total market. In addition, because the population buying life insurance products and employer-sponsored coverage is younger, the average age of long-term care insurance buyers will decline.

Long-term care insurance products are providing expanded and more uniform benefits in response to market and regulatory pressures. These advances, however, have not come without a cost to the consumer. It is likely that the rapid pace of recent product changes and improvements will slow to allow the balance between coverage and price to stabilize. In the near term, new features (which are also likely to increase premiums), will include more comprehensive inflation features, nonforfeiture values and more extensive noninstitutional benefits.

Although not the only solution for paying the nation's long-term care bill, private insurance offers a promising source of assistance for many Americans. Steady growth and increasingly effective products will help to ensure that the insurance industry plays a role in any comprehensive financing proposal considered by federal policy makers.

Notes

1. National Association of Insurance Commissioners, "Long-Term Care Insurance Model Act," (Washington, DC, June 1990), 1.
2. J. Wiener et al., "Measuring the Activities of Daily Living Among the Elderly: Comparisons Across National Surveys," *Journal of Gerontology* (forthcoming).
3. Health Insurance Association of America, *Long-Term Care Insurance: Market Trends* (Research Bulletin, Washington, DC, March 1989), 10.
4. T. Rice, K. Thomas, and W. Weissert, *The Impact of Owning Private Long-Term Care Insurance Policies on Out-of-Pocket Costs* (American Association of Retired Persons, Washington, DC, August 1989), 73.
5. Health Insurance Association of America, *Long-Term Care Insurance*, 13.
6. Ibid., 31.
7. Ibid., 12.
8. American Council of Life Insurance, 1988 *Life Insurance Fact Book* (Washington, DC, October 1989), 58.

Appendix A

Companies Selling Long-Term Insurance

(as of June 1990)

Company names that are indented are affiliates or subsidiaries of the company above them.

Acceleration Life Insurance Company

Adjustable Life Insurance Company

* Aetna Life & Casualty[4]

* Aid Association for Lutherans

* Allstate Life Insurance Company

American Benefit Life Insurance Company

American Independent Insurance Company

* American Integrity Insurance Company

American Travellers Life Insurance Company

* AMEX Life Assurance Company

  * American Centurion Life & Accident Assurance Company

* IDS Life Insurance Company

* Associated Doctors Health and Life Insurance Company

Atlantic American Life Insurance Company

  Bankers Fidelity Life Insurance Company

Atlantic & Pacific Life Insurance Company of America

* Bankers Life and Casualty Company

  * Bankers Multiple Line Insurance Company

  * Certified Life Insurance Company

  * Union Bankers Insurance Company

Blue Cross and Blue Shield of Arizona

Blue Cross and Blue Shield of Connecticut

Hawaii Medical Service Association

Blue Cross and Blue Shield of Indiana

Blue Cross and Blue Shield of Iowa

Blue Cross and Blue Shield of Kansas

Blue Cross and Blue Shield of Kansas City

Blue Cross and Blue Shield of Kentucky

Blue Cross and Blue Shield of Maryland

Blue Cross and Blue Shield of Minnesota

Blue Cross and Blue Shield of Montana

Blue Cross and Blue Shield of the National Capital Area

Combined Services, Inc.
  (subsidiary of Blue Cross/Shield of NH)

Finger Lakes LTC Insurance Company[1]
  (subsidiary of Blue Cross/Shield of Rochester)

Group Insurance Services
  (subsidiary of Blue Cross/Shield of NC)

Blue Cross and Blue Shield of North Dakota

Medical Life Insurance Company
  (subsidiary of Blue Cross/Shield Mutual of Northern OH)

Consumer Services Casualty Insurance Company
  (subsidiary of Blue Cross of Western PA)

Group Services, Inc.
  (subsidiary of Blue Cross/Shield of UT)

Blue Cross and Blue Shield of West Virginia

Blue Cross and Blue Shield of Wyoming

Blue Cross of Washington and Alaska

* Bradford National Life Insurance Company

* Business Men's Assurance Company of America[2]

Calfarm Life Insurance Company[2]

* Central Life Assurance Company[2]

* Central States Health and Life Company of Omaha

Appendix A

(continued)

Cologne Reinsurance Company[6]
* Colonial Life & Accident Insurance Company[2]
Columbia Life Insurance Company
  Columbia Accident and Health Insurance Company
* Combined Insurance Company of America
Commonwealth Life Insurance Company
* Continental Casualty Company (CNA)[1]
  * Valley Forge Life Insurance Company[2]
* Continental General Insurance Company[2]
Continental Western Life Insurance Company
* Country Life Insurance Company
Employers Modern Life Company[2]
Equitable Life and Casualty Company
* Federal Home Life Insurance Company
  * Harvest Life Insurance Company
First National Life Insurance Company
First Penn Pacific Life Insurance Company[2]
First United American Life Insurance Company
* Gerber Life Insurance Company
Golden Rule Insurance Company[2]
Great Fidelity Life Insurance Company
Great Republic Insurance Company
Hartford Insurance Company
Independence Nursing Insurance Company
Integrity National Insurance Company
ITT Life Insurance Company[2]
Jefferson National Life Insurance Company[2]
* John Alden Life Insurance Company
* John Hancock Mutual Life Insurance Company[1]
* Kansas City Life Insurance Company[2]
* Life Investors Insurance Company of America
  Bankers United Life Assurance Company[2]
    * NN Investors Life Insurance Company
  Pacific Fidelity Life Insurance Company[2]
Life and Health Insurance Company of America
Lincoln Benefit Life Company[2]
* Lincoln National Life Insurance Company[2]
* Lutheran Brotherhood
* Medico Life Insurance Company
  * Mutual Protective Insurance Company
* Metropolitan Life Insurance Company[3]
MidAmerican Mutual Life Insurance Company
The Midland Mutual Life Insurance Company
* MONY Financial Services
* Mutual of Omaha[1]
National Foundation Life Insurance Company
* National States Insurance Company
* National Travelers Life Insurance Company[2]
* New York Life Insurance Company
* North American Life & Casualty Company
Northwestern National Life Insurance Company
Old American Life Insurance Company

Appendix A

(continued)

Old Southern Life

* Pan-American Life Insurance Company[2]

Pekin Life Insurance Company

Penn Treaty Insurance Company

People's Security Life Insurance Company

* Physicians Mututal Insurance Company

Pilgrim Life Insurance Company

Pioneer Life Insurance Company of Illinois

* The Principal Financial Group[4]

* Provident Life and Accident Insurance Company

Providers Fidelity Life Insurance Company

* Prudential Insurance Company of America

Pyramid Life Insurance Company

Security Connecticut Life Insurance Company[2]

* Sentry Life Insurance Company

* Shelter Life Insurance Company of America[2]

* Standard Life & Accident Insurance Company

State Life Insurance Company of Indianapolis[2]

* Sunset Life Insurance Company of America[2]

* Time Insurance Company

* Transport Life Insurance

* The Travelers Insurance Company[1]

Twentieth Century Life Insurance Company

US Life Insurance Company[2]

  All American Life Insurance Company[2]

  Old Line Life Insurance Company of America[2]

  United States Life Insurance Company of New York[2]

* Union Labor Life Insurance Company

* United American Insurance Company

* United Farm Bureau Family Life Insurance Company[2]

United General Life Insurance Company

United Security Assurance Company of Pennsylvania

* UNUM Life Insurance Company[5]

Washington Health Services

World Life and Health Insurance Company of Pennsylvania

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* HIAA Member Company

Unless otherwise noted, all companies listed provide an individual or group association plan.

[1] Provides an individual and employer-sponsored plan.

[2] Offered as part of a life insurance policy.

[3] Provides an employer-sponsored plan and coverage to members of a continuing care retirement community.

[4] Provides an employer-sponsored plan.

[5] Provides coverage to employer groups and specifically defined senior-age groups, including retirement housing.

[6] Provides coverage to members of a continuing care retirement community.

SOURCES: Health Insurance Association of America and Blue Cross and Blue Shield Association.

June 1990

Appendix B

Blue Cross and Blue Shield Plans Selling Long-Term Care Insurance as of June 1990

Blue Cross and Blue Shield of Arizona
Blue Cross and Blue Shield of Connecticut
Hawaii Medical Services Association
Blue Cross and Blue Shield of Indiana
Blue Cross and Blue Shield of Iowa
Blue Cross and Blue Shield of Kansas
Blue Cross and Blue Shield of Kansas City
Blue Cross and Blue Shield of Kentucky
Blue Cross and Blue Shield of Maryland
Blue Cross and Blue Shield of Minnesota
Blue Cross and Blue Shield of Montana
Blue Cross and Blue Shield of the National Capital Area
Combined Services, Inc.
  (Subsidiary of Blue Cross/Shield of New Hampshire)
Finger Lakes LTC Insurance Company
  (Subsidiary of Blue Cross/Shield of Rochester)
Group Insurance Services
  (Subsidiary of Blue Cross/Shield of North Carolina)
Blue Cross and Blue Shield of North Dakota
Medical Life Insurance Company
  (Subsidiary of Blue Cross/Shield Mutual of Northern Ohio)
Consumer Services Casualty Insurance Company
  (Subsidiary of Blue Cross/Shield of Utah)
Blue Cross and Blue Shield of West Virginia
Blue Cross and Blue Shield of Wyoming
Blue Cross of Washington and Alaska

Source: Blue Cross and Blue Shield Association

Appendix C

Companies Offering Long-Term Care Coverage as Part of a Life Insurance Policy as of June 1990

- All American Life Insurance Company
- Bankers United Life Assurance Company
- Business Men's Assurance Company of America
- Calfarm Life Insurance Company
- Central Life Assurance Company
- Colonial Life and Accident Insurance Company
- Continental General Insurance Company
- Continental Western Life Insurance Company
- Employers Modern Life Company
- First Penn Pacific Life Insurance Company
- Golden Rule Insurance Company
- ITT Life Insurance Company
- Jefferson National Life Insurance Company
- Kansas City Life Insurance Company
- Lincoln Benefit Life Company
- Lincoln National Life Insurance Company
- National Travelers Life Insurance Company
- Old Line Life Insurance Company of America
- Pacific Fidelity Life Insurance Company
- Pan-American Life Insurance Company
- Security Connecticut Life Insurance Company
- Shelter Life Insurance Company
- State Life Insurance Company of Indianapolis
- Sunset Life Insurance Company
- United Farm Bureau Life Insurance Company
- United States Life Insurance Company
- United States Life Insurance Company of New York
- Valley Forge Life Insurance Company

Source: HIAA

HIAA

Health Insurance Association of America
1025 Connecticut Ave., N.W.
Washington, D.C. 20036-3998

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HIAA

RESEARCH BULLETIN

Long-Term Care Financing Proposals: Their Costs, Benefits and Impact on Private Insurance

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LifePlans, Inc.

January 1991

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For a copy of this bulletin, please write to:
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Foreword

In 1989, the Health Insurance Association of America (HIAA), contracted with LifePlans, Inc., a research and consulting firm specializing in long-term care, to conduct a study on long-term care financing alternatives. The purpose of the study was to examine not only the costs of various financing approaches, but to determine who would benefit from additional public spending and to examine the appropriateness of financing alternatives relative to various public policy goals.

Central to the discussion is the question: Do upper- or lower-income elderly benefit most from changes in public policy? Finding answers to such questions, coupled with realistic cost projections, enables policy makers to make more informed decisions about appropriate approaches to the long-term care financing problem.

Moreover, policy makers and other interested parties need analytic tools that can incorporate realistic responses to changes in public policies. For example, how does the supply and demand for private long-term care insurance change in response to different public policies? By understanding the interaction of the private market with public policies, policy makers can more accurately judge the overall impact of different government approaches and develop solutions which optimize public and private sector responsibilities.

Another important feature of the LifePlans project is the development of a PC-based long-term care financing model that allows policy makers to simulate alternative financing approaches simply and quickly. Computer-based models that are flexible, simple, and affordable are particularly useful, given the large number of competing long-term care financing proposals and the ever-changing parameters of each. While all quantitative modeling tools have drawbacks, they offer the best means for comparing the relative magnitude of changes in public policy.

Before the LifePlans study, no research had been done in the long-term care financing arena that successfully addressed the distributional issues related to "who benefits" and "who pays" for new public long-term care financing programs. To this end, HIAA believes LifePlans' contribution to the long-term care financing debate is original and noteworthy.

Susan Van Gelder
Associate Director
Department of Policy Development & Research

Background

Long-term care costs have become the major catastrophic health expense faced by older people. A single year in a nursing home can cost more than $25,000, and nearly two in five individuals over age 65 will spend at least some time in a nursing home. About 42 percent of these expenses are paid for by the federal government and states through Medicaid programs, and more than 50 percent are paid for by the recipients of care or their families.

The current means of financing long-term care—state Medicaid programs and individual out-of-pocket payments—leave middle-income elderly in the position of having to make difficult choices when seeking long-term care services. They can pay out of pocket, make arrangements to receive services from families or friends, divest their assets to qualify for Medicaid, or go without care. Escalating costs, questionable adherence to quality standards in long-term care facilities, and access problems have led to a widespread demand in both the public and private sectors for a new approach to financing this needed service.

The Study

The aim of this project was to develop an accessible computer-based quantitative model to analyze the fiscal effects of a variety of public and private proposals for long-term care financing. Because data are generally lacking for the population under age 65, the model was designed to analyze the impact of these proposals on the current elderly population.

The objectives were to:

- Describe the elderly population in 1990 by sociodemographic characteristics, economic status, long-term care service use patterns, and demand for private insurance (base case).
- Analyze public policy initiatives in long-term care financing, including a social insurance program that provides back-

end catastrophic protection; a social insurance program that pays first-dollar coverage for a limited period of time; a targeted public program; and a program that subsidizes the purchase of private long-term care insurance.

- Analyze the fiscal effect of public policy initiatives in terms of total government spending on long-term care; the distribution of long-term care costs across payer sources; the distribution of program benefits across age and income groups; the distribution of payment burden across generations; and the development of the private insurance market.

Public and Private Financing Roles

The government (Medicare and Medicaid) currently pays for roughly one-half of all long-term care expenses, and there have been a number of proposals and recommendations for expanded public financing of these services. The myriad and divergent legislative proposals now being considered are evidence that a consensus on the public role has not yet emerged. In general, proposed public approaches fall into three major categories:

- Social insurance for all or part of long-term care;
- A targeted public approach building on the Medicaid program; and
- Stimulation of the private market through tax clarifications, subsidies, and education.

Over the past five years, private sector involvement in financing long-term care has grown considerably. By mid-1990, more than 130 insurance companies were writing long-term care insurance policies and more than 1.6 million policies had been sold to almost 4 percent of the elderly. Between 1987 and 1989 alone, long-term care insurance policy sales increased about 35 percent each year. Moreover, activity in the employer group market has been increasing steadily, with a number of major firms committed to offering plans to employees as part of their benefit packages.

Many believe that private long-term care insurance coverage can have its greatest impact in the employer group market because premiums are lower and more affordable at younger ages and little or no underwriting is required because people in this cohort are healthier. In addition, employers can educate their employees about long-term care and help select the plan that best meets their employees' needs.

By mid-1990, more than 150 employers had agreed to offer a long-term care insurance plan to their employees. Most of the plans also were offered to employees' spouses, retirees and their spouses and the parents and parents-in-law of the employees. On average, 5.2 percent of all employees elected coverage for an employee pay-all plan, although in some cases participation rates were as high as 37 percent. The average age of an employee electing coverage through an employer plan was 43, when the average premium was about $200 a year.

If trends persist, the private long-term care insurance market will continue to develop alongside existing public programs. Private and public programs together have addressed successfully a number of social welfare concerns, such as retirement income security, health care financing, and disability protection. The history of social welfare programs in this country, as well as the interests of the private and public sectors, strongly suggests that, over time, long-term care services will be financed with a mixture of public and private programs, the combination of which is unclear.

There are two basic views regarding public and private roles in financing long-term care. One holds that government must take the lead in solving the problem, leaving the private sector to fill in small gaps similar to acute health care financing for the aged, with Medicare and Medicare supplemental policies. Another view is that public intervention should be determined by the inability or failure of the private sector to meet social and financing goals. Based on evidence, it is premature to suggest that there is market failure in this area. The recent entry of a significant number of private insurers has eliminated one symptom of market failure: lack of interest of suppliers. Thus, a financing strategy that incorporates private and public sectors is appropriate for the 1990s, whereas it may not have been at the beginning of the previous decade.

Potential Market for Private Long-Term Care Insurance

To analyze the potential of private insurance to finance long-term care, the elderly population was divided into two groups: those who could be considered potential long-term care insurance purchasers, and those for whom the purchase of private insurance makes little sense, based on their income and assets, private insurance premium levels, their potential eligibility for Medicaid, or their health status.

The purchase criteria for long-term care insurance was based on a combination of three factors–income levels, asset levels, and age. Minimum asset levels increase across age groups at each income level. For example, a potential long-term care insurance buyer with an annual income in the $10,000 to $14,999 range would have to have assets of $20,000 at age 65, $30,000 at age 75 and $50,000 at age 85 to consider purchasing the product. (See Table 1.)

The proportion of elderly individuals who, on the basis of both health status and income/asset status, are considered potential purchasers of long-term care insurance is presented in Table 2. Whereas about half the elderly could afford to purchase a policy, about 15 percent of them currently are disabled with long-term care needs and therefore would not qualify. Thus, 42 percent of the current elderly population can purchase a private long-term care insurance policy. Because premiums for long-term care insurance are based on age at time of purchase and remain level over time, the proportion of younger elderly, those aged 65 to 74, able to afford a policy is much higher.

Table 1

Minimum Asset Levels for Potential Buyers of Long-Term Care Insurance by Income Level

	By age group and asset level		
Income level	*65-74*	*75-84*	*85 and over*
<10,000	>$30,000	>$50,000	>$100,000
$10,000 - $14,999	>$20,000	>$30,000	>$ 50,000
$15,000 - $29,999	>$15,000	>$20,000	>$ 40,000
>$30,000	>$15,000	>$20,000	>$ 40,000

Source: LifePlans estimates based on insurance industry consultation.

Table 2

Eligible Elderly Market for Long-Term Care Insurance

	Percentage ineligible based on:				Total percentage qualifying
Age group	*Income & asset*	*Disabled in nursing home*	*Disabled in community*	*Total combined**	
65 to 74	46%	1%	7%	50%	50%
75 to 84	54	6	10	62	38
85 and up	82	21	24	92	8
Weighted total	52	5	10	58	42

* The total percentage ineligible reflects the overlap of those not qualifying because of income, assets, and health status

Sources: LifePlans estimates; 1982 and 1984 National Long-Term Care Surveys; 1985 National Nursing Home Survey; Income of the Population Age 55 and Over; and Survey of Income and Program Participation.

This analysis indicates that the private sector does have the potential to insure a significant portion of the population against long-term care costs. It is necessary to differentiate, however, between being able to afford insurance and the demand for it. The decision to purchase insurance is based on financial factors and other considerations, such as individual attitudes about the importance of purchasing insurance and recognition of potential risk. Currently, a significant gap exists between demand and affordability, and only about 4 percent of the elderly, or about 10 percent of those elderly able to purchase a plan, have done so. Moreover, if public policy is not articulated for long-term care during the 1990s, the number insured in the year 2000 will still be far below the percentage that could afford it.

Major Findings of the LifePlans Model

The LifePlans long-term care model used data from the U.S. Census Bureau, the 1985 National Nursing Home Survey, and the 1982 and 1984 National Long-Term Care Surveys. It generated the following estimates on the elderly population and long-term care utilization and costs for 1990, the baseline against which all policy alternatives were compared. All estimates are for 1990.

◆ Demographic Profile

- There are 31.8 million persons aged 65 or older.
- People over age 80 are in the fastest-growing age group.
- About 60 percent of individuals over age 65 are female. Of those above age 85, about 85 percent are female.
- Half of all elderly have incomes greater than $15,000 and liquid assets greater than $20,000.

◆ Service Use

- At any given time, about 4.5 percent (1.4 million), of the elderly reside in nursing homes and another 12.2 percent (4.0 million) are disabled and live in the community.

- Over the course of the year, about 1.7 million persons use nursing homes and 4.4 million persons remain in the community but are disabled.

◆ Long-Term Care Costs

- Total long-term care costs are expected to exceed $50 billion.
- About $45 billion will be spent on nursing home care and $8 billion on home care.
- Over their lifetimes, about 15 percent of the elderly will incur long-term care costs greater than $80,000. Most long-term care expenses (67 percent) are incurred by individuals over age 80.
- About 15 percent of nursing home entrants begin their stays as private-paying patients and then spend down to Medicaid eligibility levels.
- About 35 percent of nursing home entrants receive Medicaid within the first month of residence.

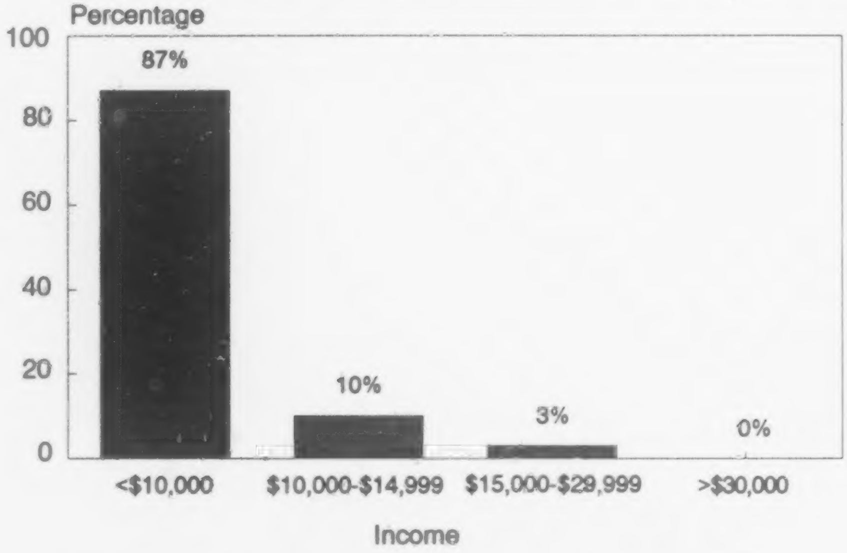
Additional Costs and Benefits of Alternative Financing Approaches

In order to compare the additional costs and benefits of new long-term care financing proposals, the LifePlans model first generated 1990 baseline estimates of current Medicaid spending for nursing home and home health care. Not surprisingly, given the nature of the Medicaid program, the estimated $19.2 billion dollars it spent on long-term care was largely for lower-income elderly groups. The vast majority of recipients, 87 percent, had annual incomes below $10,000. (See Figure 1.)

The model then simulated four alternative public approaches to financing long-term care. Cost and benefit estimates produced by the model assumed that the programs were fully operational in 1990 to allow direct comparisons to the model's baseline data for the same time period. Not modeled was the

Distribution of Medicaid Long-Term Care Dollars by Elderly Income Groups, 1990

Current Medicaid: $19.2 Billion



Source: LifePlans, Inc., Long-Term Care Model, 1990

Figure 1

impact of new public financing initiatives on Medicare, which accounts for roughly 5 percent of long-term care expenditures. Thus, in the subsequent discussion, public costs refer to Medicaid and the costs of new public initiatives. The four alternative financing approaches that were modeled and analyzed were:

- A social insurance program that pays for care after individuals meet a large deductible (i.e., provides so-called back-end catastrophic protection). This program pays 80 percent of nursing home costs after a two-year nursing home stay and 80 percent of home care costs after an annual $500 deductible is met.
- A social insurance program that provides benefits for only a limited period of time (i.e., provides so-called front-end protection). This program pays the first year of nursing home care and all home care costs.

- **A targeted public program that provides care to those with financial and physical need (i.e., Medicaid reform). This program increases asset limits for Medicaid nursing-home benefit eligibility from $2,000 to $12,000 for all individuals.**
- **A program that subsidizes the purchase of private insurance. The subsidy provides a 50 percent contribution toward long-term care insurance premiums to individuals with incomes less than $15,000 and a 25 percent subsidy to those with incomes between $15,000 and $29,999. No subsidy is provided to those with incomes above $30,000.**

◆ Social Insurance Approaches

Public programs that provide social insurance for either first-dollar or back-end long-term care costs are expensive. Depending on the program, the additional public costs are between $15 billion and $20 billion. These programs provide benefits primarily to middle- and upper-income individuals, many of whom could afford to purchase private insurance. Under both back-end and front-end proposals, about one-third of those persons benefitting from the programs have incomes greater than $30,000 a year and have a level of assets which would suggest a financial capacity for purchasing long-term care insurance. (See Figure 2.) A front-end public program also would significantly reduce the proportion of individuals spending down to Medicaid while in nursing homes.

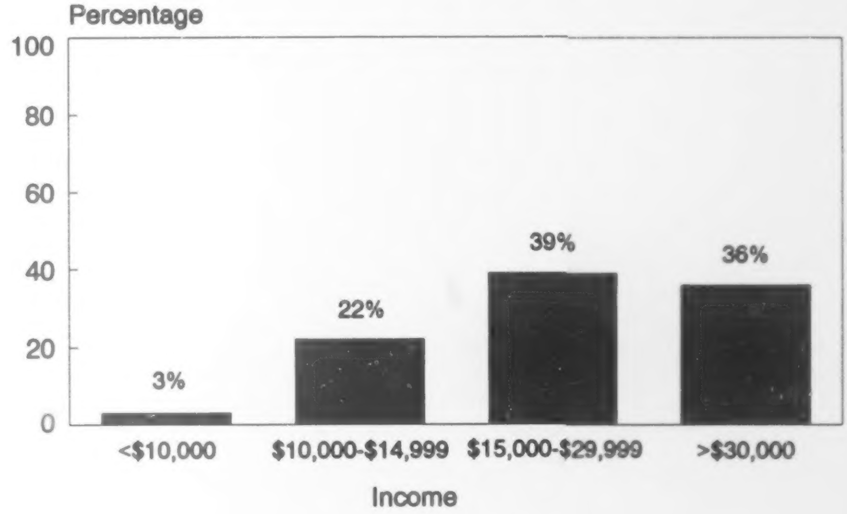
These programs provide limited additional benefits to individuals who have no alternative financing mechanisms available to them, since their long-term care costs already are covered by Medicaid. Moreover, they place the government in the position of using tax dollars essentially to preserve the assets of elderly individuals.

◆ Medicaid Reform

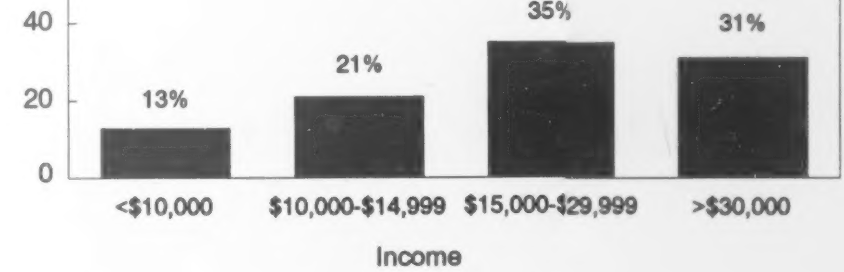
A targeted public approach, such as improving Medicaid's nursing home benefit, is less costly (about $3 billion) and helps lower-income groups. Two-thirds of those who would benefit from new public spending have incomes below $15,000. (See

Distribution of Additional Public Long-Term Care Dollars by Elderly Income Groups under Two Social Insurance Approaches, 1990

Back-End Program–Additional Public Funding: $15.3 Billion

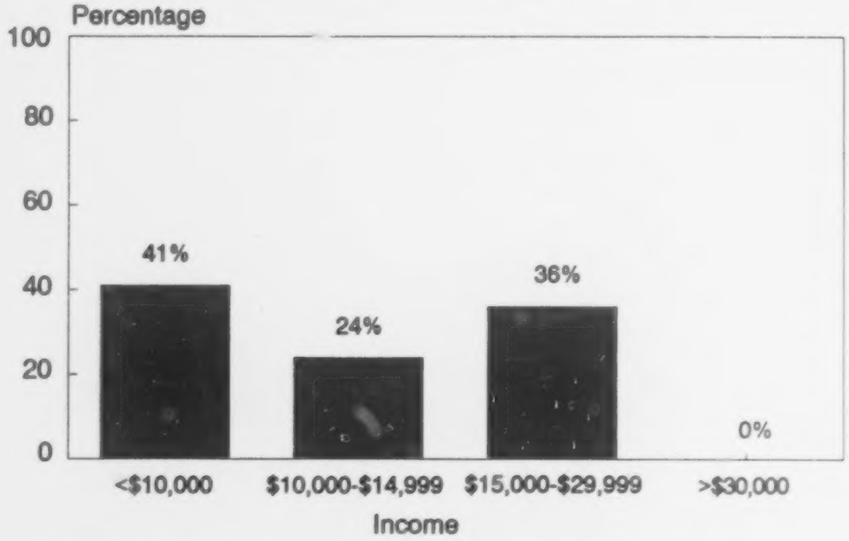


Front-End Program–Additional Public Funding: $19.7 Billion



Source: LifePlans, Inc., Long-Term Care Model, 1990

Figure 2



Distribution of Additional Long-Term Care Dollars by Elderly Income Groups under Medicaid Reform, 1990

Additional Public Funding: $3.2 Billion

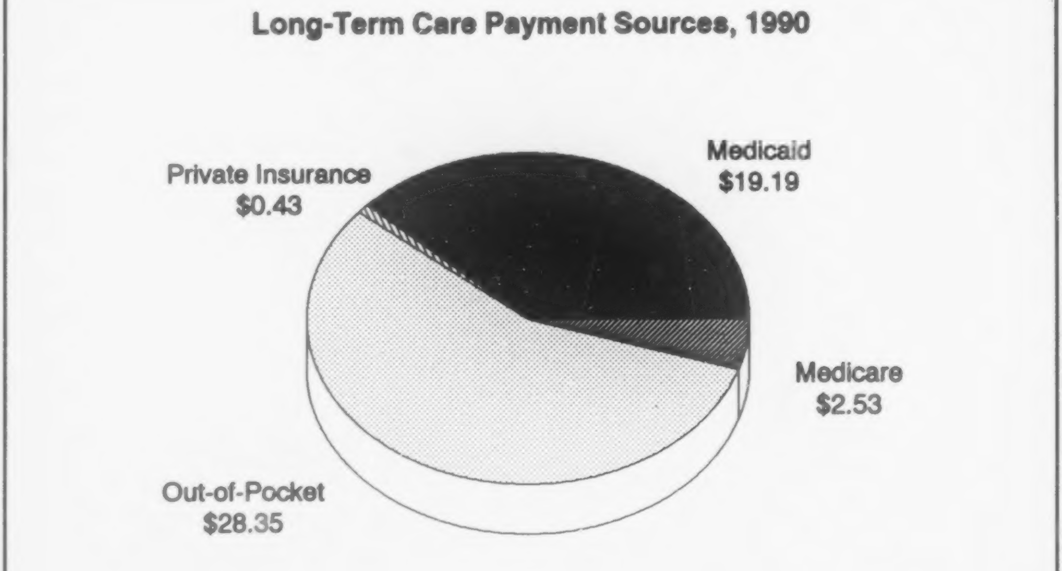
Source: LifePlans, Inc., Long-Term Care Model, 1990
(Because of rounding, numbers exceed 100%.)

Figure 3

Figure 3.) Such a program would reduce the proportion of individuals spending down to Medicaid eligibility levels and for those returning home, it would give them the additional resources needed to ease the transition–an appropriate public policy goal. Benefits would accrue to individuals who have no alternative financing sources, rather than to those who have options of either purchasing long-term care insurance or paying for care themselves.

◆ Premium Subsidy

A premium subsidy has only a modest short-term effect on increasing the number of elderly with private insurance, because current demand is so low. Although the subsidy is estimated to cost an additional $350 million, the percentage of elderly who would purchase private insurance as a result of the subsidy increases to only 5.2 percent of the elderly in 1990. This however, is a 33 percent increase over the model's



Source: LifePlans, Inc., Long-Term Care Model, 1990

Figure 4

baseline estimate of 3.9 percent. Most, 77 percent, of the new public spending would benefit those elderly with incomes between $10,000 and $15,000. The model is based on today's relatively low demand for private insurance. Over a longer period, the most significant public policies affecting the demand for private insurance must include those that address the public's attitudes, knowledge, and concerns about long-term care risks and long-term care insurance products.

Total Costs and Benefits of Alternative Financing Approaches

The LifePlans model indicates that Medicaid and out-of-pocket payments were the primary payers of long-term care in 1990. Private insurance and Medicare paid only $3 billion of the total $50.5 billion estimated for all long-term care services. (See Figure 4.)

◆ Back-End Coverage

The model estimates that a program providing back-end catastrophic protection would cost $23.86 billion in 1990. A similar program was introduced in the 100th Congress by Sen. George Mitchell (D-Maine) in his bill, S. 2305. Both Medicaid and out-of-pocket expenditures for long-term care would be substantially reduced, as these expenditures would now be assumed under the new program. Although expenditures covered by private insurance would increase due to paying the 20 percent copayment for nursing home stays longer than two years, the model estimates that fewer elderly would purchase private insurance under this form of public program.

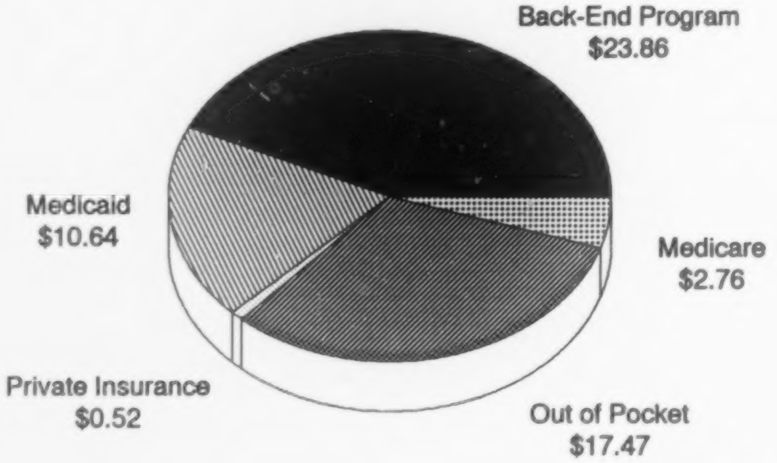
According to the LifePlans analysis, fewer elderly would feel the need to purchase insurance, given the certainty that all but two years of a nursing home stay will be covered by the government. If the insurance industry were to tailor a private plan to complement this new public program, that is, one which would cover the first two years of nursing home care plus a 20 percent copayment on subsequent years, then market penetration would decline from its current 3.9 percent to 3.1 percent in 1990.

Under a back-end social insurance approach, individuals with incomes greater than $30,000 would receive the largest marginal benefits. People in this group would receive benefits 1,000+ times greater than they do currently if a back-end approach were adopted. Individuals with incomes between $15,000 and $30,000 would receive 900 times more benefits than they do currently. Based on their asset levels and age, the analysis also indicates that a high proportion of individuals in these groups could afford to purchase private insurance. The major benefit of this type of public program is that it provides asset protection to upper- and middle-income elderly and their families. (See Figure 5.)

◆ Front-End Coverage

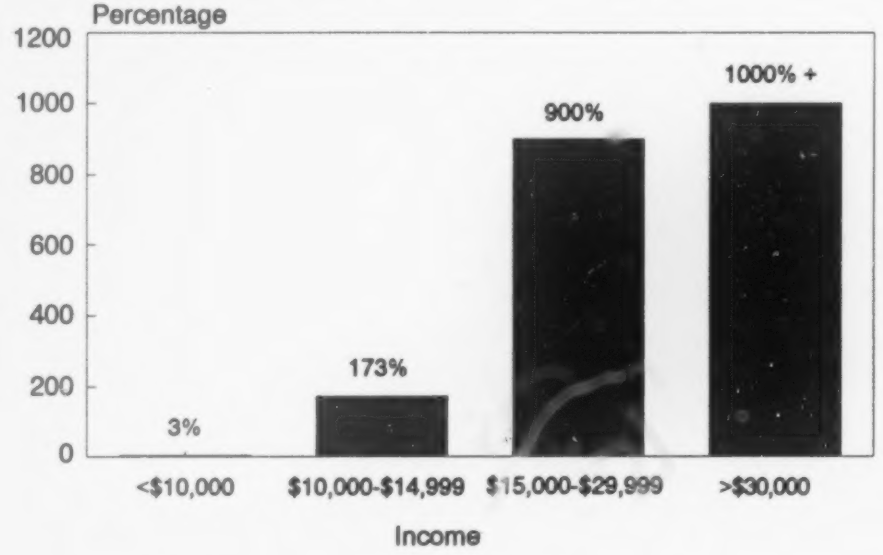
The LifePlans model estimates that a program paying front-end coverage would cost about $27 billion annually. Sen. Edward

Long-Term Care Payment Sources under a Back-End Program, 1990



Percentage Change in Public Long-Term Care Dollars Received by Elderly Income Groups, 1990

(Current Spending Versus Back-End Program)



Source: LifePlans, Inc., Long-Term Care Model, 1990

Figure 5

Kennedy (D-Massachusetts) introduced similar legislation, S. 2163, in the 101st Congress. A front-end social insurance approach would reduce Medicaid and out-of-pocket expenditures similar to a back-end program, because prior expenditures from these two sources would now be assumed under the new program.

A front-end program, however, would have a greater impact on reducing Medicaid costs compared to a back-end catastrophic program. Benefits would accrue to the 15 percent of nursing home entrants who would otherwise have spent down to Medicaid eligibility. The program helps prevent spend-down and covers brief nursing home stays for individuals who are most likely to return to their homes.

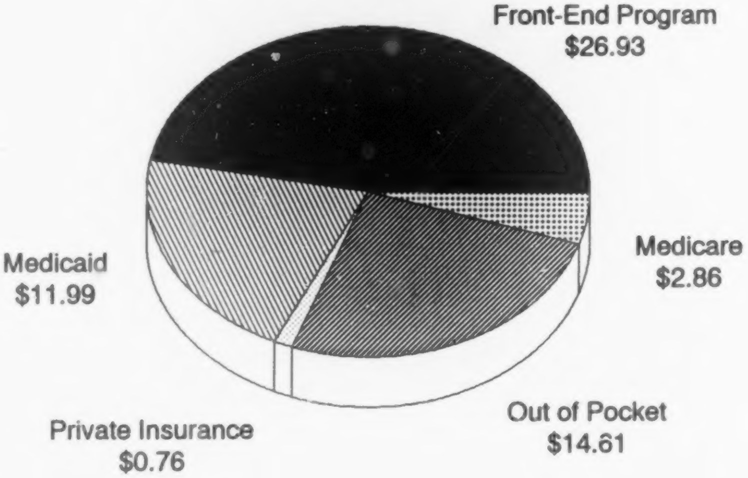
Expenditures covered by private insurance would increase from current levels. According to the LifePlans analysis, more elderly would be covered by private insurance under this public policy change because individuals remain exposed to the risk of incurring catastrophic expenses and the cost of private coverage significantly declines when the public sector pays for the first year of nursing home costs. If the insurance industry were to respond to this new public program by offering a private plan to cover nursing home costs after a one-year deductible, then the impact over a single year would be to increase the number of policyholders by 13 percent.

Individuals with incomes greater than $15,000 would receive the largest marginal benefits. Compared to current public spending, they would receive over 1,000 times more in benefits than they do currently. Their age and asset profiles also indicate that a high proportion would be able to afford private long-term care insurance. For those with incomes less than $10,000, the net increase in public benefits would be less than 20 percent. (See Figure 6.)

◆ Improved Medicaid Program

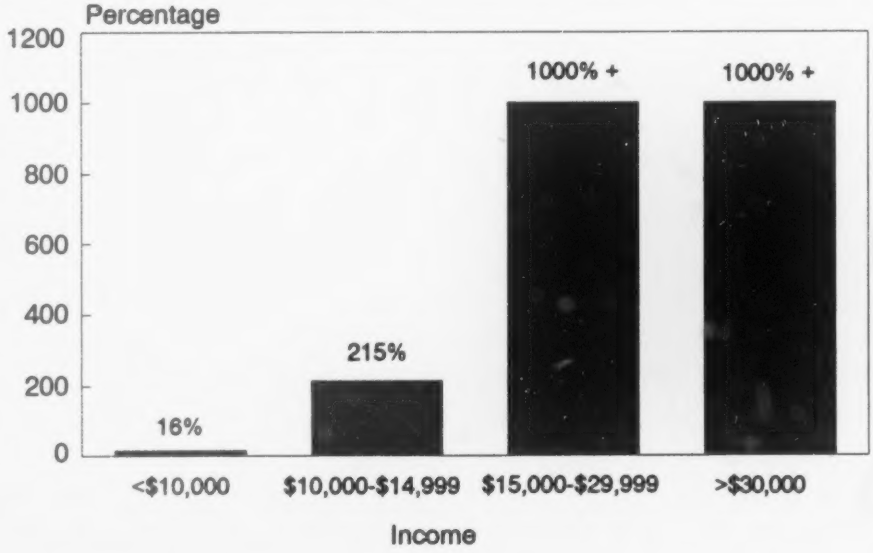
The LifePlans model estimates that expanding the Medicaid program by allowing persons to keep $12,000 in assets, yet still qualify for nursing home coverage, would cost about $3 billion

Long-Term Care Payment Sources under a Front-End Program, 1990



Percentage Change in Public Long-Term Care Dollars Received by Elderly Income Groups, 1990

(Current Spending Versus Front-End Program)



Source: LifePlans, Inc., Long-Term Care Model, 1990

Figure 6

in 1990. The net increase in benefits for the $10,000-to-$14,999 income group would be 70 percent, whereas for the $15,000-to- $29,999 group, the increase would be 129 percent. No benefits would be gained by those with incomes above $30,000. (See Figure 7.)

Overall, 80 percent of total Medicaid dollars would accrue to individuals with incomes less than $10,000, whereas only 8 percent would be received by individuals with incomes between $15,000 and $29,999. The proportion of nursing home entrants depleting their assets to Medicaid eligibility levels would decline from 15 percent to 7 percent. The number of individuals eligible for Medicaid upon entry to a nursing home would increase from 35 percent to 53 percent.

◆ Premium Subsidy

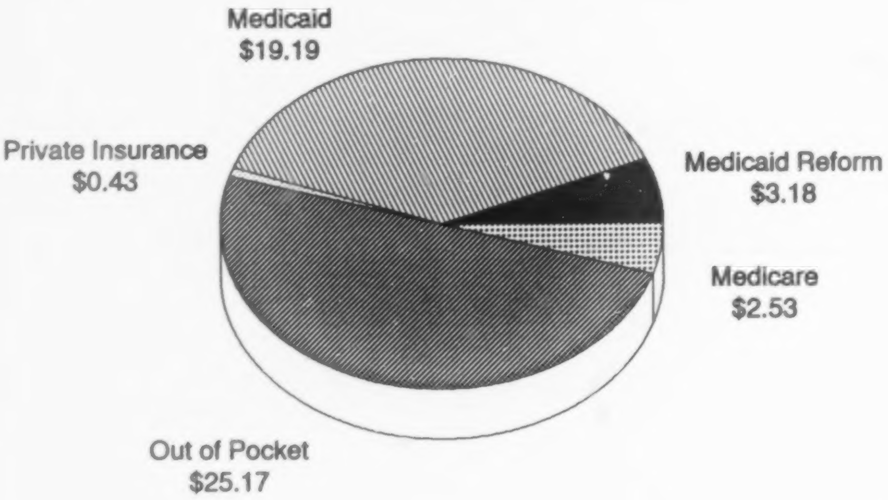
Of the four proposals modeled by LifePlans, the premium subsidy would be least expensive, $350 million. Because it is designed to assist persons with incomes below $30,000, those with incomes between $15,000 and $30,000 would receive the greatest increase, 45 percent, in public benefits. Long-term care expenditures paid by private insurance also would increase compared to the model's baseline, from $.43 billion to $.58 billion in 1990.

Implications of Major Findings

In the late 1970s, when Congress first recognized the long-term care financing problem, the options for federally financing its costs included social insurance, state revenue enhancements, and categorical grants. There were few private insurance plans for long-term care, and the private sector had not shown an inclination to enter the market. Hence, private market failure became a strong rationale for public financing. Based on the findings of this analysis and the current significant interest shown by private carriers, presuming market failure seems premature.

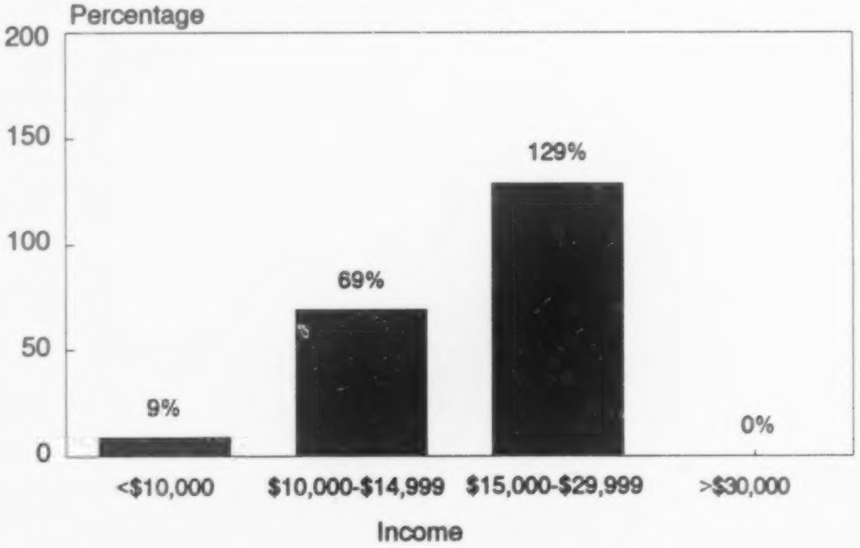
Arguments favoring social insurance now must focus on the inequities and inefficiencies of private insurance. One argu-

Long-Term Care Payment Sources under Medicaid Reform, 1990



Percentage Change in Public Long-Term Care Dollars Received by Elderly Income Groups, 1990

(Current Spending Versus Medicaid Reform)



Source: LifePlans, Inc., Long-Term Care Model, 1990
(Because of rounding, numbers exceed 200%.)

Figure 7

ment for a social insurance approach is that it offers greater equity in access to benefits. Private insurance companies use diverse underwriting and benefit determination criteria, which can result in denial of insurance to those who need or are at high risk of needing long-term care services. Since social insurance solves this problem, it should lead to a broader sharing of long-term care expenses. Another argument for a social insurance approach is that selling costs would be eliminated; hence, the money saved in eliminating marketing and sales costs can purchase greater benefits. Finally, in a private market, products may not incorporate desired consumer protection features.

While these arguments merit consideration, a number of issues relating to the financing, degree of risk-spreading and specific program features need to be considered. Each of these is discussed in turn.

◆ Financing

A social insurance program would be justified in part if only a small percentage of those at risk can afford private insurance. On the basis of income and assets, however, almost half of the population over age 65 today can afford to purchase private long-term care insurance and an even greater number of working adults can afford it.

Many beneficiaries of proposed public initiatives also can afford private insurance, unless the program is designed specifically for those in low-income groups. A key question is whether the federal government wants to implement a public program that for many people would serve as an asset protection plan.

One potential disadvantage of a social insurance approach, given the increased wealth of many older individuals (when compared to earlier generations of older people), is that it leads to intergenerational asset transfers. Private insurance policies prefund expenses and hence do not lead to intergenerational transfers. This has an equity appeal of its own.

All the long-term care financing proposals on the public agenda will require additional revenues of $5 billion to $20 billion annually. Each of the proposals depends in varying degrees on one or more of the following sources of additional money: an increase in Social Security tax (FICA) rates and/or an increase on maximum taxable FICA earnings; a proportional increase in personal federal income tax rates; and an increase in federal estate tax rates and estate recoveries under Medicaid.

The effective tax bases of these financing mechanisms are different. The FICA tax now is applied to wages up to a maximum taxable amount. The federal personal tax differs from FICA in that it is progressive and it is applied to income generated from both labor and capital. The estate tax can be viewed as a capital-income tax.

Given the different revenue base for each of these taxes, there are implications for money transfers between generations, between labor and capital, and among individuals of the same generation. Therefore, selecting the type or types of tax by which long-term care services will be financed is critical.

For example, households headed by people aged 25 to 54 account for more than three-quarters of total labor income but less than one-third of capital income. The elderly account for only 3.7 percent of labor income, but 45 percent of capital income. The analysis indicates that in the near term almost all benefits from proposed long-term care programs will be received by the elderly who would pay only 3.7 cents of every dollar financed through the FICA tax or would pay only 13.4 cents per dollar if long-term care is financed through income taxes. (See Boskin, Kotlifkoff and Knetter, National Bureau of Economic Research, "Changes in the Age Distribution of Income in the United States, 1968-1984," Working Paper No 1766, Cambridge, Mass., October 1985, and LifePlans, Inc., estimates.)

◆ Spreading Risk

In large part, it may not be premium price and income, but rather the newness of the market, buyer reticence, information asymmetry, and the lack of a clearly enunciated government policy that explain the low demand for private long-term care insurance. The public simply has not been educated about the value of this type of insurance; closing the gap between the potential market and actual market penetration requires public education to change attitudes and misperceptions. Policy makers should work to change public attitudes toward risk spreading in general, so as to avoid another debacle similar to the one following the enactment of the Medicare Catastrophic Care Act of 1988 (repealed hardly more than a year later).

If all people over age 65 who could afford long-term care insurance tried to buy it, about 15 percent of them would not be eligible because of insurance company underwriting practices. If individuals select an insurance policy while still working, then this percentage will become smaller over time. The current disabled elderly population could be served by a separate risk pool—either a subsidized buy-in for Medicaid or private insurance.

◆ Program Features

While long-term care in general is a social issue, the selection of appropriate long-term care services is highly personal. Therefore, the issue of choice is significant. Social insurance will reduce consumer choice, while the private sector, even today, offers diverse policies allowing individuals to make decisions about the nature and type of care desired.

There have been significant improvements in long-term care products during the past five years. Three major design trends have emerged. First, benefit periods are longer. Second, benefits have become more comprehensive, providing home- and community-based services as well as institutional care. Finally, insurers have started to view long-term care insurance as a combination of disability and health insurance, rather than as an extension of health care insurance or a high-option Medicare supplemental policy.

Consumer choice has to be balanced by consumer protection. Recently, media attention has focused on the exploitative practices of a few private insurers and agents, compounding the confusion and uncertainty faced by the elderly. Justifiably, the public wants accountability and product reliability. Group sponsors such as employers can play a crucial role in the long run, but government must lead the way in consumer protection.

The focus of consumer protection, however, should not be on market-driven design features such as premiums and benefit durations. Rather, true value rests on the adequacy of the product to meet long-term care needs, the reasonableness and timeliness of underwriting, the development of equitable criteria for determining benefit eligibility, and the insurance company's commitment and financial ability to remain in the market for the long run.

The success of government initiatives will depend on close cooperation between federal and state governments. Historically, state governments have regulated insurance, while the federal government has provided guidance using tax policy and other methods of support. A similar delineation of roles may be effective in the area of long-term care financing.

Recommendations and Conclusions

The most important task facing health policy makers is defining the boundaries and roles of the public and private sectors in meeting the needs of the elderly in regard to long-term care financing. Recent world events suggest that governments are rethinking their roles as managers of the general economy, and are moving toward market-based solutions, reflecting, in part, the restrictiveness and inefficiencies that plague large bureaucracies. The debate on the public role in long-term care cannot be immune from this scrutiny. If government were absolved from the need to manage and administer a large public program, then its resources and energy could be better focused on regulating and channeling the private sector in the interest of the public good.

The study's findings indicate that government policy should perform the following key functions:

- Address the problems faced by those who cannot afford to protect themselves against catastrophic long-term care expenses, either because of their health status or because of their incomes and assets levels;
- Educate the public on the risk and nature of long-term care costs and the shortcomings that exist in current government programs;
- Provide incentives to encourage the working population and older people to protect against catastrophic long-term care expenses; and
- Develop a consumer protection strategy that focuses on screening out bad carriers and supporting innovative high-value products that offer wide consumer choice.

For less than $10 billion in 1990, the federal government could meet the long-term care goals of providing better access to care, reducing the number of individuals spending down to Medicaid, encouraging individuals to protect their assets through private insurance, and supporting individuals' desire to remain in the community. Such a program would incorporate the following elements:

◆ Enhanced Medicaid

- Increase asset eligibility thresholds for elderly individuals using nursing home care, perhaps to $12,000.
- Increase income and asset thresholds for elderly disabled individuals in the community to ensure more widespread access to home care benefits.

◆ Tax Law Changes

- Provide a tax subsidy for the purchase of private insurance policies to people whose incomes are below a specified level and clarify the nature of long-term care insurance in the federal tax code.

◆ Public Education & Regulation

- Support an educational program that clearly spells out what long-term care costs, what government programs do and do not cover, and assists states in the regulation of long-term care insurance products.

This four-part program is straightforward in intent because government would distinguish its long-term care programs and services from what is expected from the private market. Whereas all long-stay nursing home residents would have access to care through a more humane Medicaid program, the federal government would be looking to the private sector to provide asset protection and risk-pooling for those who can afford to purchase private insurance.

It may not be feasible or desirable for the less wealthy elderly to pay for private insurance. For them, an improved Medicaid program with expanded eligibility for both nursing home and home care benefits offers real advantages over current policy. LifePlans estimates that a home care benefit based on functional disability and moderate-to-low income and asset eligibility levels would cost roughly $4 billion annually. The subsidy for purchase of private insurance, coupled with consumer protection, would be an inexpensive way to identify high-value products and would provide direction for private sector initiatives. It also will send a strong signal that government sees a significant role for the private sector.

More important than tax subsidies, however, may be clarifying the nature of long-term care insurance plans in the federal tax code. Such clarifications will assure that employer premium contributions are excluded from an individual's taxable income, that coverage can be offered in cafeteria plans like health insurance can, and that long-term care benefits will be excluded from the income of the policyholder. These provisions are common to health insurance but uncertain for long-term care insurance. Such clarifications should stimulate greater employer participation in long-term care insurance programs and would enable the employed to protect themselves more effectively against future long-term care costs.

Moreover, such a strategy stands to save the government significant money in the future, as fewer individuals will spend down to Medicaid.

The extent of the financing problem for long-term care, the appropriateness of pooling risk or insurance as the preferred means of financing, and the inability of the private sector to provide a national solution all necessitate increased government involvement. Even though the health insurance industry will be expected to play a more substantial role in financing this care, private initiatives will not be able to achieve their full potential without supportive public policies. Ultimately, the success or failure of the private sector in tackling this problem will depend on the nature and scope of government interventions.

◆ LifePlans, Inc.

The Boston-based firm of LifePlans, Inc. was established in 1987 by academic researchers interested in working with insurers, providers, and policy makers to enhance and broaden the long-term care insurance options available to the elderly and employee groups under age 65. LifePlans specializes in design and implementation of risk- and care-management services for insurance companies, group purchasers, and providers of long-term care services. The company also assists in the development of long-term care reinsurance partnerships. LifePlans' principals conduct public policy analyses of proposed legislation affecting long-term care services and insurance.

The authors of *Long-Term Care Financing Proposals: Their Costs, Benefits and Impact on Private Insurance* are based in Boston, Massachusetts, with LifePlans, Inc., and Boston University. The authors would like to recognize Professor Lawrence Kotlikoff of Boston University for his analysis of the intra- and inter-generational effects of public long-term care financing iniatives.

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